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Attorneys for Defendants
HCC LIFE INSURANCE COMPANY and HCC MEDICAL INSURANCE SERVICES, LLC
(erroneously sued as TOKIO MARINE HCC – MEDICAL INSURANCE SERVICES GROUP)

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA – OAKLAND DIVISION

MOHAMMED AZAD and DANIELLE BUCKLEY, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

TOKIO MARINE HCC – MEDICAL INSURANCE SERVICES GROUP, HEALTH INSURANCE INNOVATIONS, INC., HCC LIFE INSURANCE COMPANY, and CONSUMER BENEFITS OF AMERICA,

Defendants.

Case No.: 4:17-cv-00618-PJH

DECLARATION OF JON PADGETT IN SUPPORT OF HCC LIFE INSURANCE COMPANY AND HCC MEDICAL INSURANCE SERVICES, LLC'S MOTION TO DISMISS AND THEIR ALTERNATIVE MOTION TO STRIKE CLASS ALLEGATIONS

Date: May 24, 2017
Time: 9:00 a.m.
Ctrm : 3

Complaint Filed: February 7, 2017

I, Jon Padgett, hereby say and declare as follows:

1. I am Vice President of Claims and Compliance at HCC Medical Insurance Services, LLC. HCC Medical Insurance Services, LLC administers Short Term Medical ("STM") insurance policies issued by HCC Life Insurance Company (collectively, "HCC"). I have worked for HCC for around ten (10) years, and have held my current position since January 2015. As part of my duties and responsibilities, I am familiar with how the STM product is advertised, issued, and administered. I have personal knowledge of the matters set forth in this declaration and, if called as a witness, I could and would testify competently thereto.

2. HCC's website, referenced at paragraphs 42-46, 49, 54 and footnotes 9 and 10 of the Class Action Complaint ("Complaint"), is located at http://www.hccmis.com. Attached hereto as Exhibits 1 through 10, are true and correct copies of certain materials, described further below, as they appeared on the HCC website as of the times when Plaintiffs Mohammed Azad and Danielle Buckley's purchases were made in, respectively, December 2015 and April 2016.

3. Exhibit 1 is a screenshot of the top portion of the HCC website homepage.

4. Exhibit 2 is a screenshot of the "Products" tab of the HCC website homepage.

5. Exhibits 3, 4, and 5 are screenshots depicting three sets of steps a user of the HCC website could have followed to view the "Short-Term Medical" product description page of the HCC website in April 2016. A user of the HCC website could have taken either of the two sets of steps depicted in Exhibits 3 and 4 to view the "Short-Term Medical" product page in December 2015.

6. Exhibit 6 is a screenshot of the "California Short-Term Medical Insurance Plans" product page of the HCC website, as was linked from the "Short-Term Medical" product page.

7. Exhibit 7 is a specimen California STM Certificate, referenced at paragraph 54 of the Complaint, and Exhibit 8 is a screenshot demonstrating its link from the "California Short-Term Medical Insurance Plans" product page (Exhibit 6).

8. Exhibits 9 and 10 are screenshots depicting two sets of steps a user of the HCC website could have followed to view or download the "exemplar" "CA STM Complete" brochure referenced at paragraphs 42, 43, 44, 46, and 49 of the Complaint, and Exhibit 11 is that brochure.

9. Exhibits 12 and 13 attached hereto are true and correct copies of Mohammed Azad's application for STM coverage submitted December 8, 2015, and the Certificate of Insurance issued to him on or about that date, referenced at paragraphs 19, 20, and 21 of the Complaint.

10. The video described in paragraphs 3-4 of the Declaration of Dan Garavuso filed herewith was produced by HCC and uploaded to YouTube on March 9, 2015. A true and correct copy of that video is manually filed herewith as Exhibit 14.

11. Exhibit 15 attached hereto is a true and correct copy of the fulfillment package (containing, among other things, copies of their policy Certificate and application) emailed to Steven Buckley, Danielle Buckley's husband, upon his purchase of STM coverage for his family on or about April 1, 2016, referenced at paragraph 29 of the Complaint.

12. Exhibits 16, 17, and 18 attached hereto are true and correct copies of letters HCC sent to Azad and his medical providers (either St. Rose Hospital or [redacted]), dated February 1, 2016, February 11, 2016, and February 24, 2016, respectively, referenced at paragraph 26 of the Complaint.

13. Exhibit 19 attached hereto are true and correct copies of Explanations of Benefits sent from HCC to the Buckleys dated August 29, 2016 and August 30, 2016, referenced at paragraph 36 of the Complaint.

Pursuant to 28 U.S.C. § 1746, I declare under penalty of perjury that the foregoing is true and correct. Executed this 13th day of April, 2017, at Indianapolis, Indiana.

Jon Padgett

EXHIBIT 1

Exhibit 1

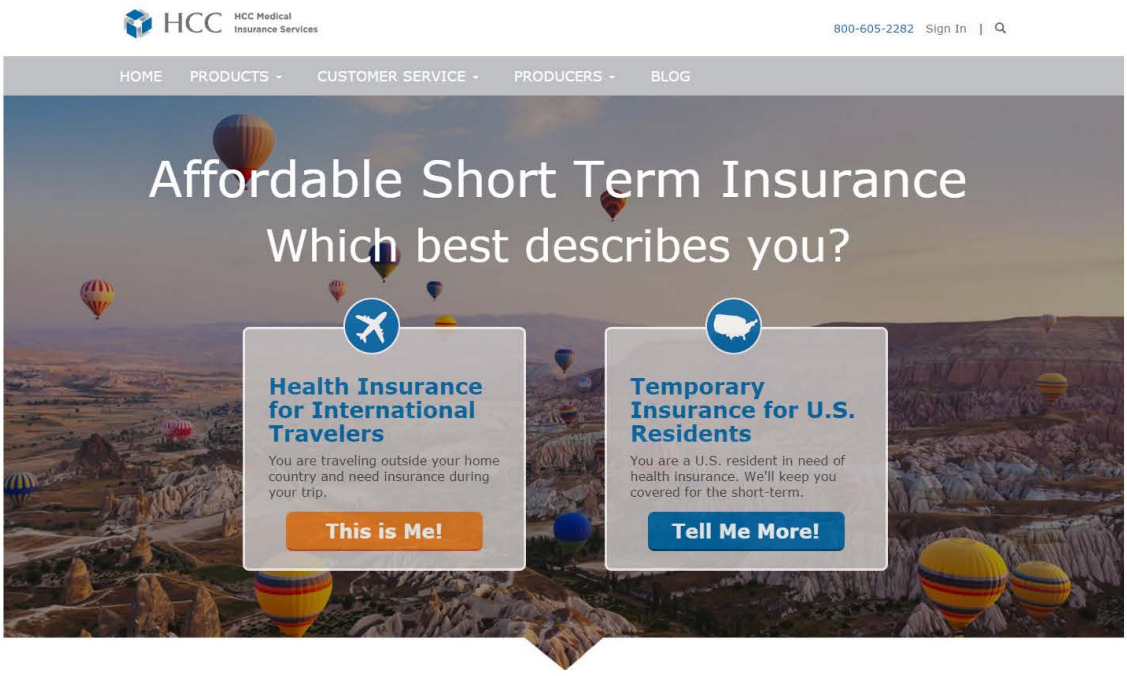
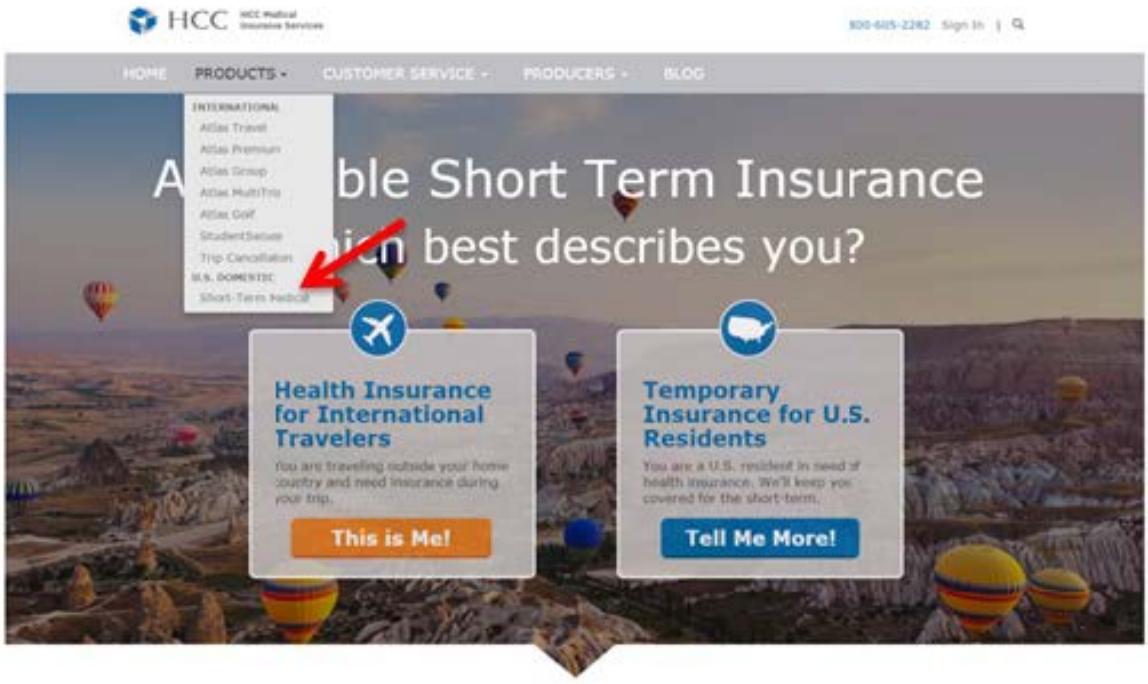

HCC
HCC Medical Insurance Services
800-605-2282
Sign In
HOME
PRODUCTS
CUSTOMER SERVICE
PRODUCERS
BLOG
Affordable Short Term Insurance
Which best describes you?
Health Insurance for International Travelers
You are traveling outside your home country and need insurance during your trip.
This is Me!
Temporary Insurance for U.S. Residents
You are a U.S. resident in need of health insurance. We'll keep you covered for the short-term.
Tell Me More!

EXHIBIT 2

Exhibit 2


HCC
HOME
PRODUCTS
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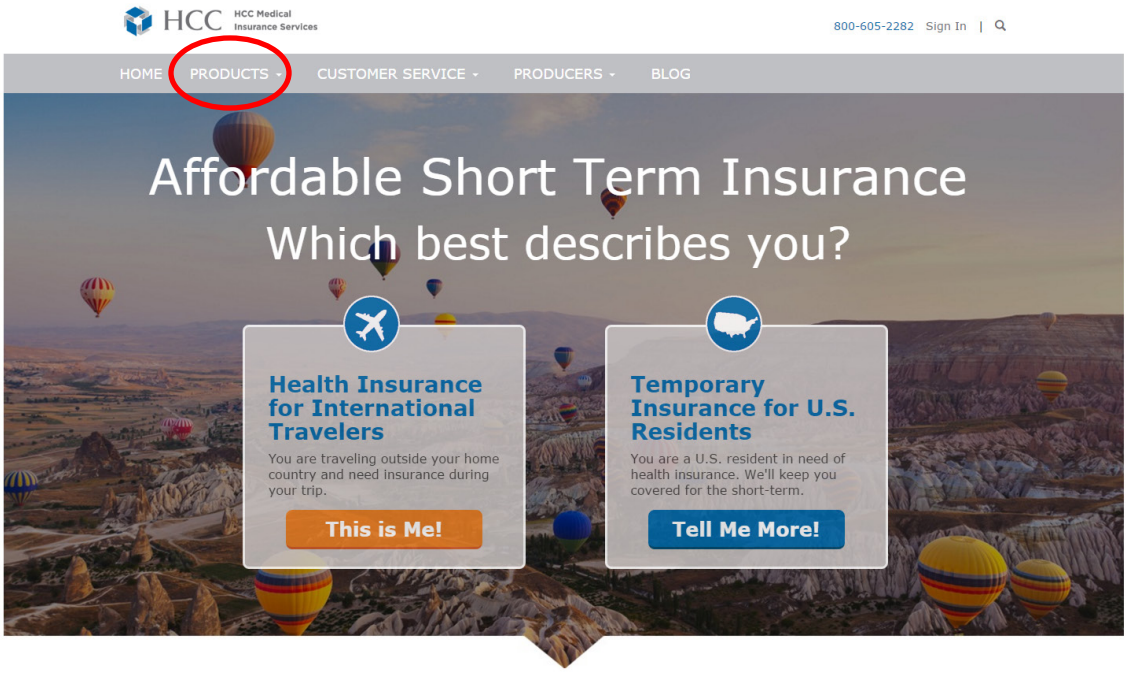
PRODUCERS
BLOG
INTERNATIONAL
Atlas Travel
Atlas Premium
Atlas Group
Atlas MultiTrip
Atlas Golf
StudentSecure
Trip Cancellation
U.S. DOMESTIC
Short-Term Medical
ble Short Term Insurance
best describes you?
Health Insurance for International Travelers
You are traveling outside your home country and need insurance during your trip.
This is Me!
Temporary Insurance for U.S. Residents
You are a U.S. resident in need of health insurance. We'll keep you covered for the short-term.
Tell Me More!

EXHIBIT 3

Exhibit 3

Step One:



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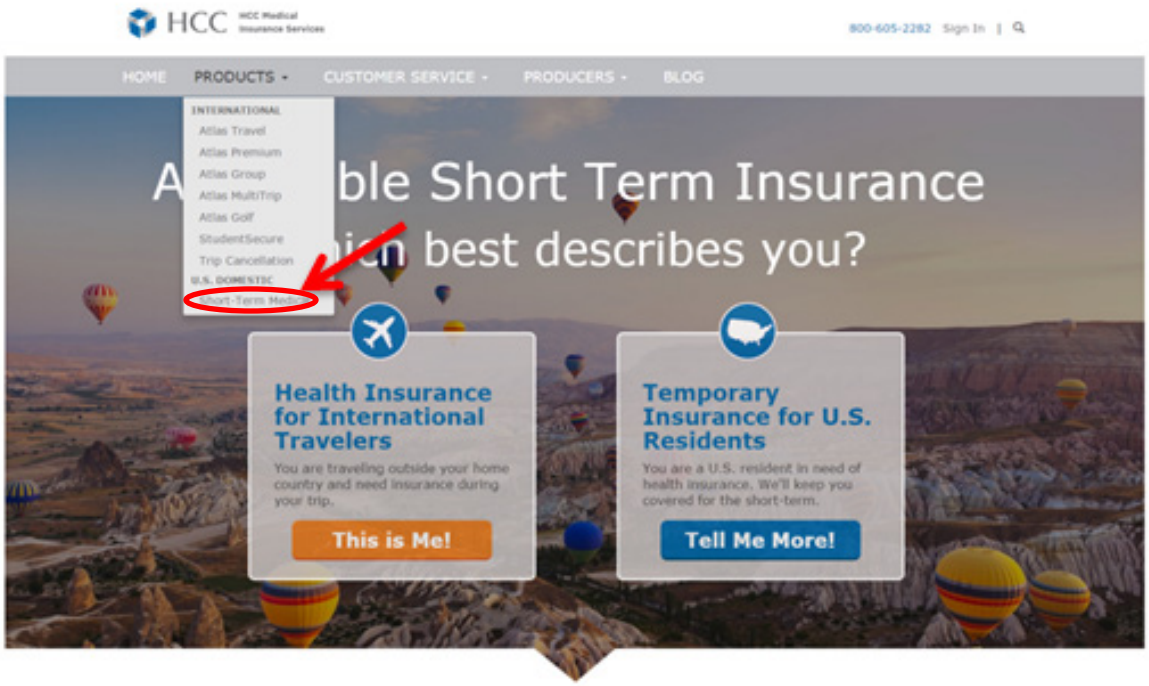

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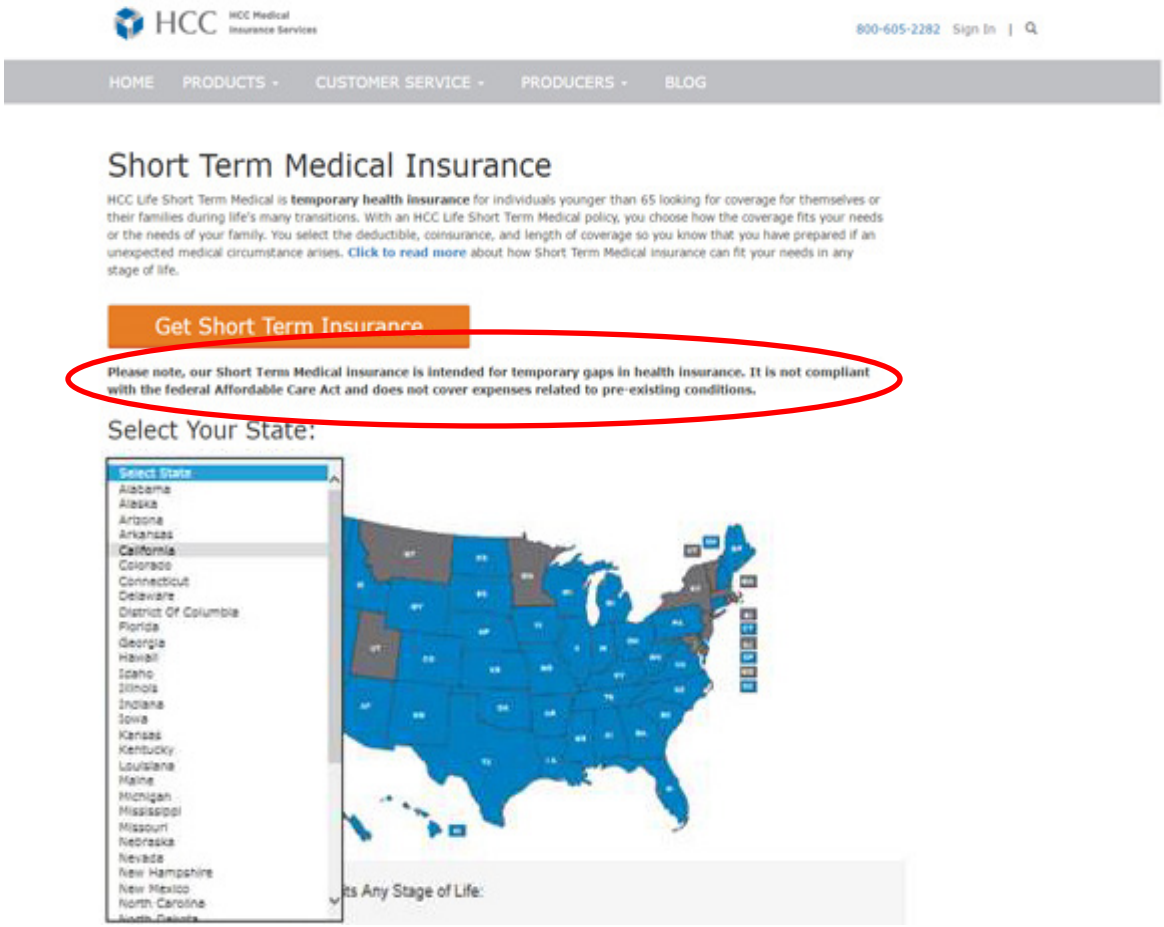
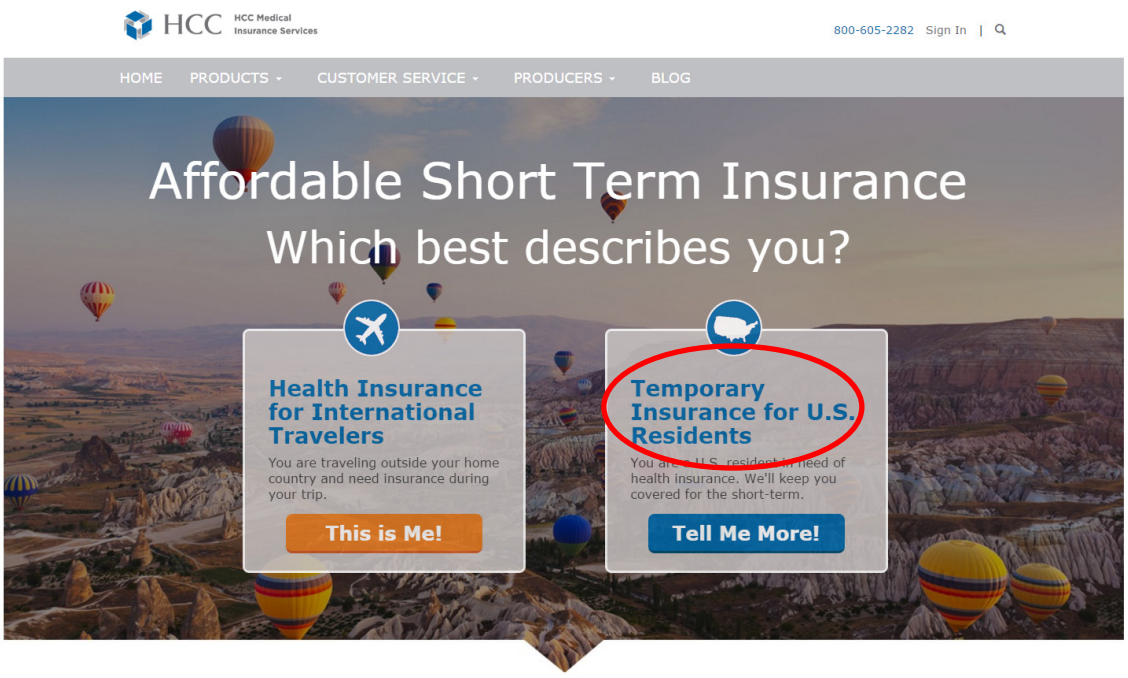

HCC
800-605-2282 Sign In
HOME
PRODUCTS
CUSTOMER SERVICE
PRODUCERS
BLOG
Short Term Medical Insurance
HCC Life Short Term Medical is temporary health insurance for individuals younger than 65 looking for coverage for themselves or their families during life's many transitions. With an HCC Life Short Term Medical policy, you choose how the coverage fits your needs or the needs of your family. You select the deductible, coinsurance, and length of coverage so you know that you have prepared if an unexpected medical circumstance arises. Click to read more about how Short Term Medical insurance can fit your needs in any stage of life.
Get Short Term Insurance
Please note, our Short Term Medical insurance is intended for temporary gaps in health insurance. It is not compliant with the federal Affordable Care Act and does not cover expenses related to pre-existing conditions.
Select Your State:
Select State
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District Of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
ts Any Stage of Life:

EXHIBIT 4

Exhibit 4

Step One:



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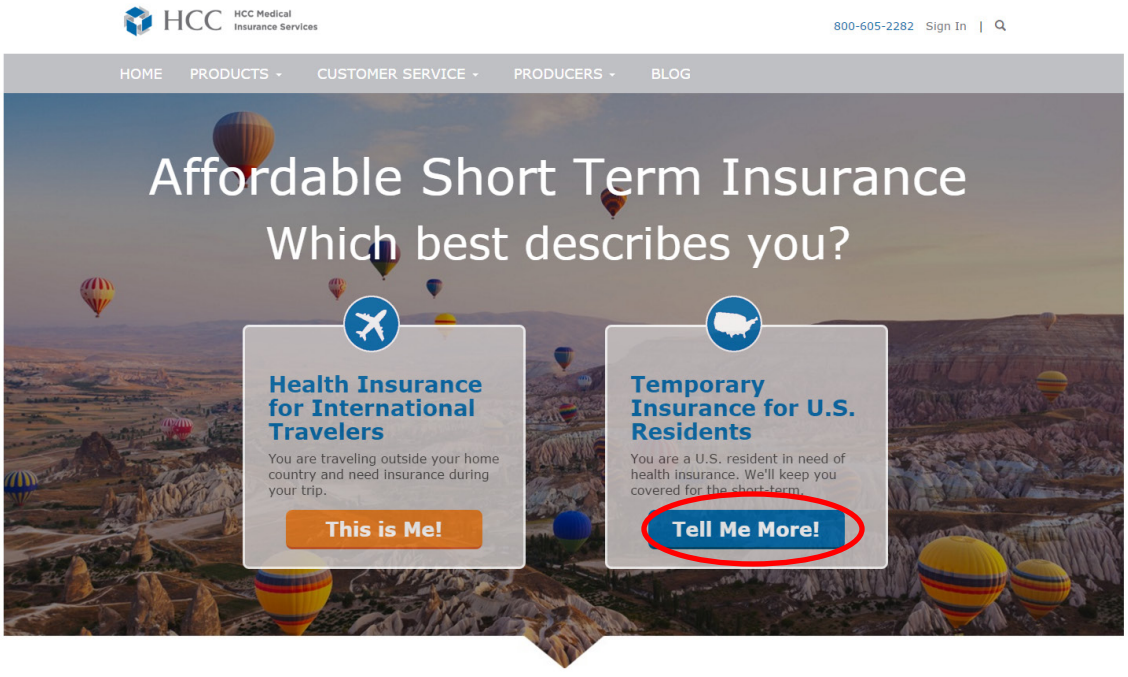

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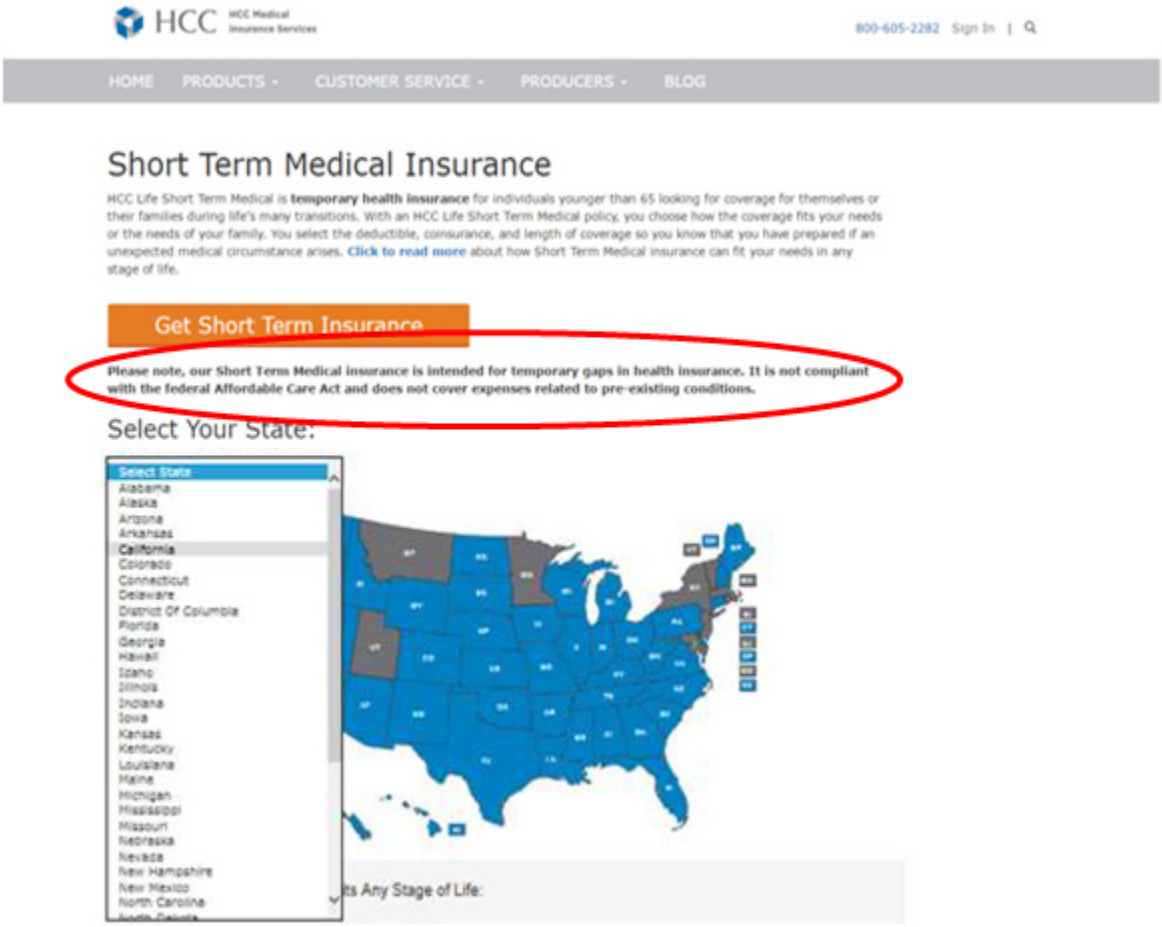
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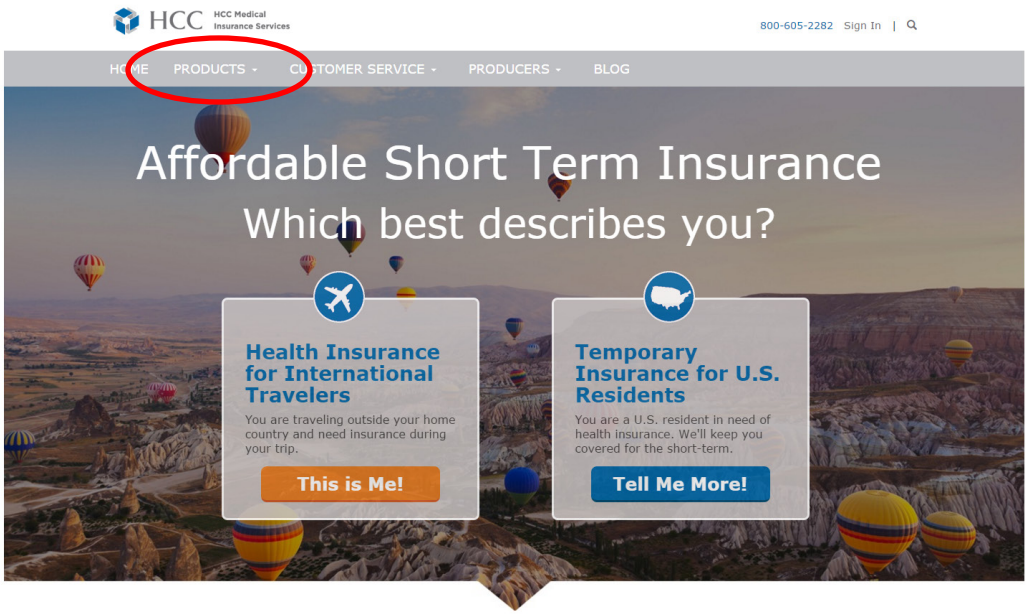
HCC Life Short Term Medical is temporary health insurance for individuals younger than 65 looking for coverage for themselves or their families during life's many transitions. With an HCC Life Short Term Medical policy, you choose how the coverage fits your needs or the needs of your family. You select the deductible, coinsurance, and length of coverage so you know that you have prepared if an unexpected medical circumstance arises. Click to read more about how Short Term Medical insurance can fit your needs in any stage of life.
Get Short Term Insurance
Please note, our Short Term Medical insurance is intended for temporary gaps in health insurance. It is not compliant with the federal Affordable Care Act and does not cover expenses related to pre-existing conditions.
Select Your State:
Select State
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District Of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
ts Any Stage of Life:

EXHIBIT 5

Exhibit 5

Step One:



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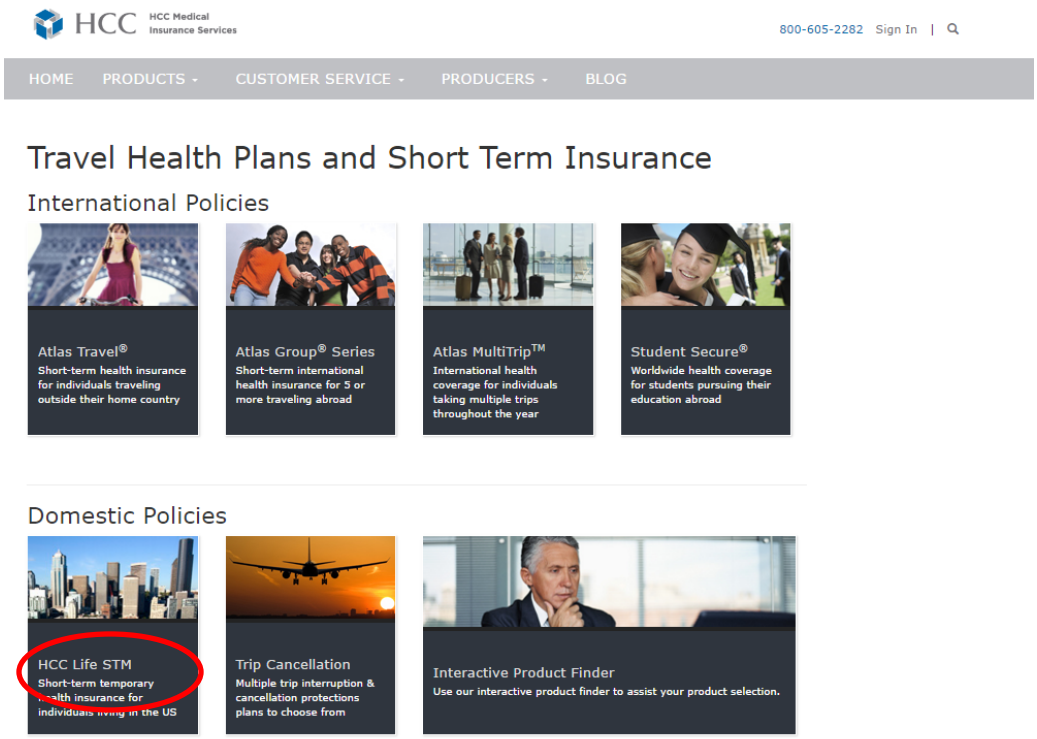

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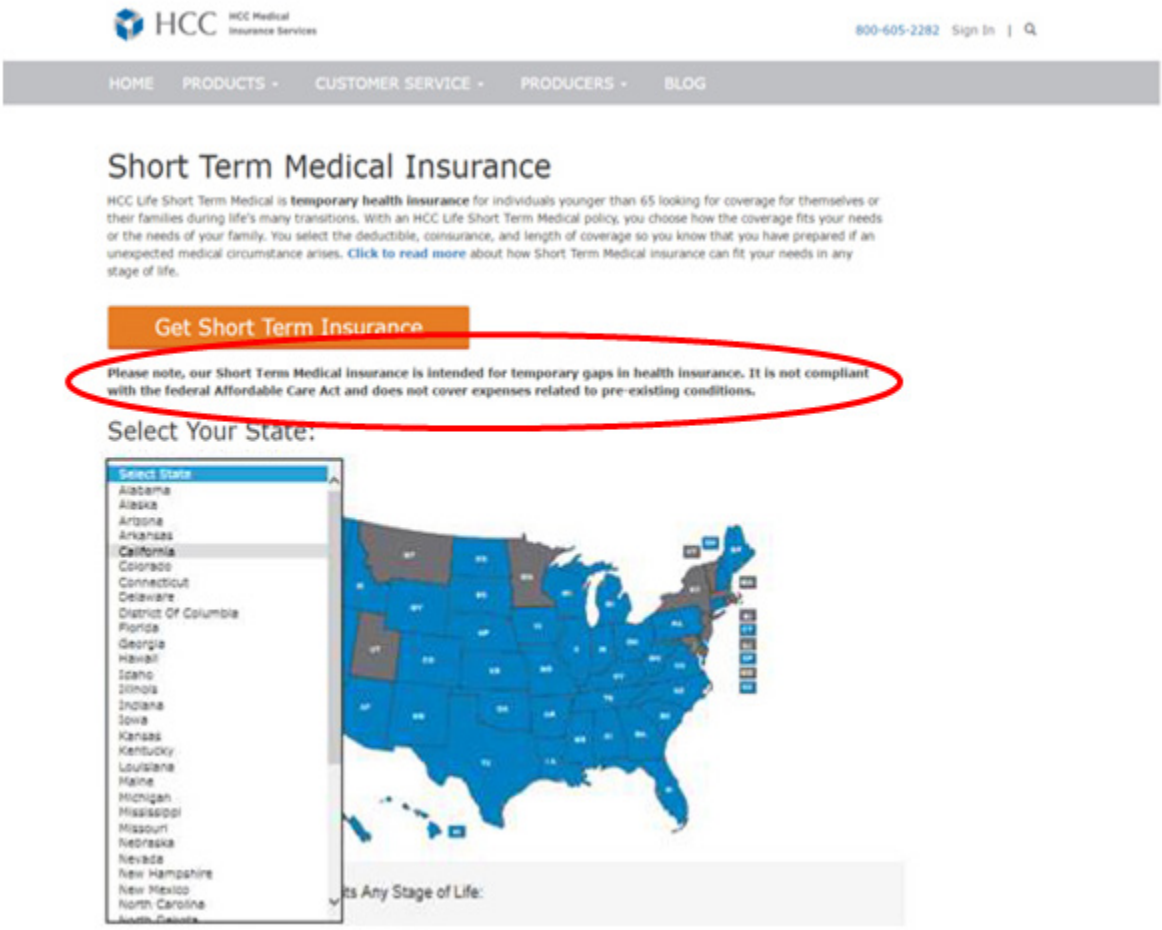
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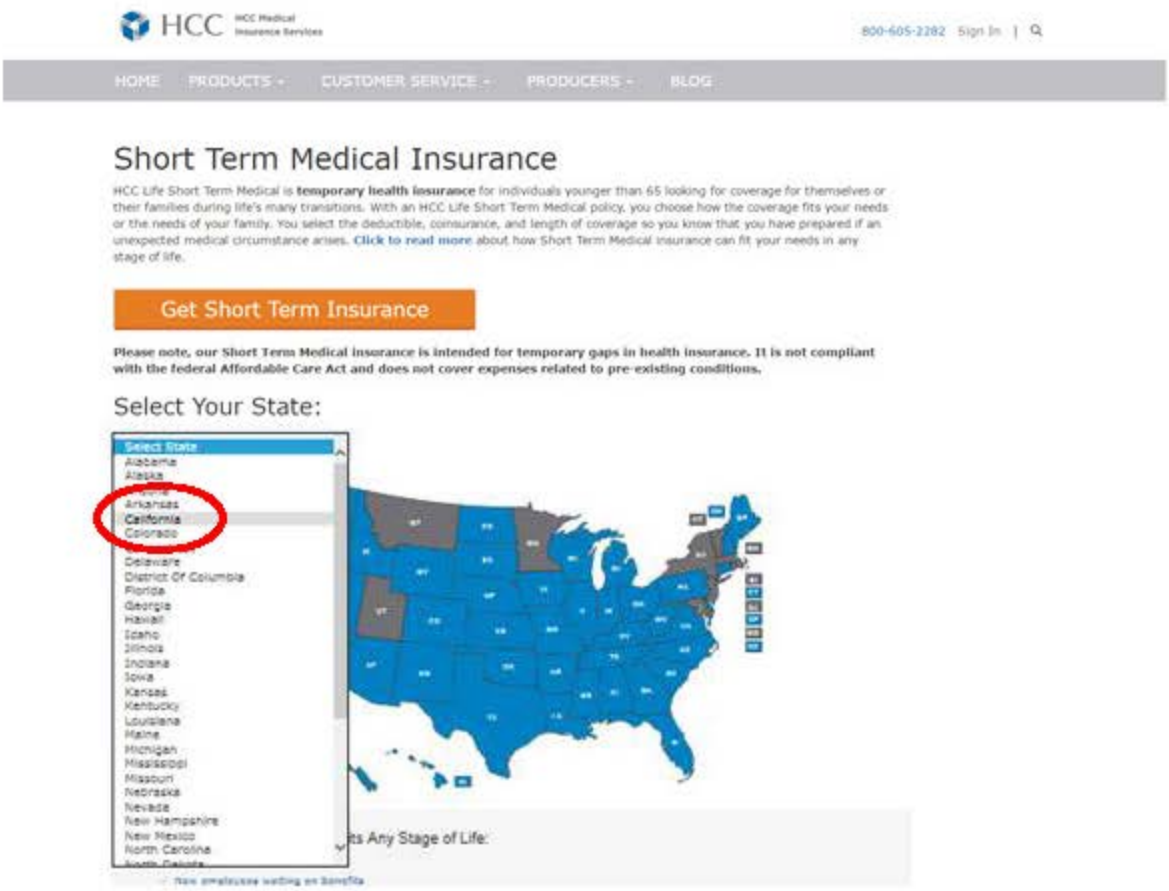
Get Short Term Insurance
Please note, our Short Term Medical insurance is intended for temporary gaps in health insurance. It is not compliant with the federal Affordable Care Act and does not cover expenses related to pre-existing conditions.
Select Your State:
Select State
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District Of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Michigan
Mississippi
Missouri
Nebraska
Nevada
New Hampshire
New Mexico
North Carolina
ts Any Stage of Life:

EXHIBIT 6

Exhibit 6

Step One:



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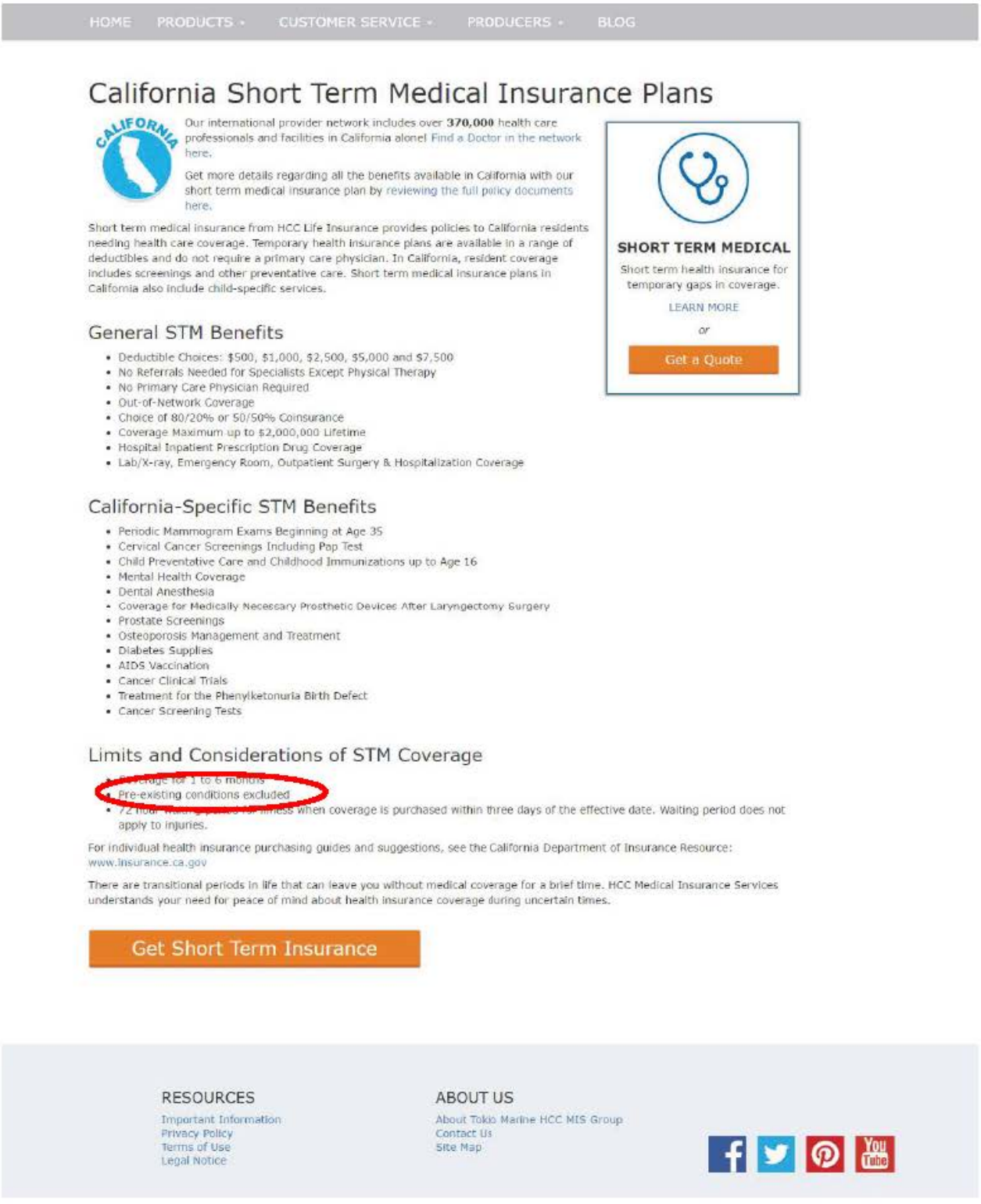


HOME PRODUCTS CUSTOMER SERVICE PRODUCERS BLOG

California Short Term Medical Insurance Plans

Our international provider network includes over **370,000** health care professionals and facilities in California alone! Find a Doctor in the network here.

Get more details regarding all the benefits available in California with our short term medical insurance plan by reviewing the full policy documents here.

Short term medical insurance from HCC Life Insurance provides policies to California residents needing health care coverage. Temporary health insurance plans are available in a range of deductibles and do not require a primary care physician. In California, resident coverage includes screenings and other preventative care. Short term medical insurance plans in California also include child-specific services.

SHORT TERM MEDICAL

Short term health insurance for temporary gaps in coverage.

LEARN MORE

or

Get a Quote

General STM Benefits

- Deductible Choices: $500, $1,000, $2,500, $5,000 and $7,500
- No Referrals Needed for Specialists Except Physical Therapy
- No Primary Care Physician Required
- Out-of-Network Coverage
- Choice of 80/20% or 50/50% Coinsurance
- Coverage Maximum up to $2,000,000 Lifetime
- Hospital Inpatient Prescription Drug Coverage
- Lab/X-ray, Emergency Room, Outpatient Surgery & Hospitalization Coverage

California-Specific STM Benefits

- Periodic Mammogram Exams Beginning at Age 35
- Cervical Cancer Screenings Including Pap Test
- Child Preventative Care and Childhood Immunizations up to Age 16
- Mental Health Coverage
- Dental Anesthesia
- Coverage for Medically Necessary Prosthetic Devices After Laryngectomy Surgery
- Prostate Screenings
- Osteoporosis Management and Treatment
- Diabetes Supplies
- AIDS Vaccination
- Cancer Clinical Trials
- Treatment for the Phenylketonuria Birth Defect
- Cancer Screening Tests

Limits and Considerations of STM Coverage

- Coverage for 1 to 6 months
- Pre-existing conditions excluded
- 72 hour [illegible] for illness when coverage is purchased within three days of the effective date. Waiting period does not apply to injuries.

For individual health insurance purchasing guides and suggestions, see the California Department of Insurance Resource: www.insurance.ca.gov

There are transitional periods in life that can leave you without medical coverage for a brief time. HCC Medical Insurance Services understands your need for peace of mind about health insurance coverage during uncertain times.

Get Short Term Insurance

RESOURCES

Important Information
Privacy Policy
Terms of Use
Legal Notice

ABOUT US

About Tokio Marine HCC MIS Group
Contact Us
Site Map

EXHIBIT 7

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
866-400-7102

CERTIFICATE OF INSURANCE
PROVIDING SHORT TERM MAJOR MEDICAL INSURANCE

Group Policy No. STM600-1 ("the policy"), has been issued to Consumer Benefits of America which we will refer to as "the Policyholder". We will refer to HCC Life Insurance Company as "the Company", "we", "us", "our".

The policy was delivered in Missouri and will be governed by the laws thereof.

This Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers can authorize a change of the policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

Signed for HCC Life Insurance Company.

_____
President

THIS CERTIFICATE IS EVIDENCE OF A CONTRACT
BETWEEN THE POLICYHOLDER AND THE COMPANY
READ IT CAREFULLY

For service or complaints about this policy, please address any inquiries to the address shown above or call 866-400-7102.

TABLE OF CONTENTS

NOTE: NO CONTINUOUS COVERAGE. This Certificate of insurance provides coverage for a short term duration only. It is not renewable.

PART I – GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes injury to one or more Covered Persons.

"Complications of Pregnancy" means:

1. Conditions requiring Inpatient treatment (when pregnancy is not terminated);
2. Whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as hyperemesis gravidarum, preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Doctor prescribed rest during the period of pregnancy, morning Sickness, and other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
3. Non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

"Congenital Condition" means a disease or other anomaly existing at or before birth, whether acquired during development or by heredity.

"Coverage Period" means the length of time which the Insured selected in the Insured's application and approved by us, not to exceed a month period commencing on the Effective Date. The Insured's Coverage Period is shown in the Schedule of Benefits.

"Covered Person" means an Insured and his eligible dependents for whom coverage is in effect under the policy, as described in Part II – Eligibility and Effective Date of Insurance Provisions and the Schedule of Benefits.

"Custodial or Convalescence Care" means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

"Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and must be satisfied each Coverage Period.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Eligible Dependent" means:

1. The Insured's lawful spouse; and
2. The Insured's unmarried children who are less than age 19. An unmarried child who is less than age 25 may also be included if the child is enrolled full-time in an accredited school or college.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures, and children for whom coverage has been court-ordered.

Dependent children (other than those for whom coverage has been court-ordered) must be primarily dependent on the Insured for principal support and maintenance.

Coverage for an unmarried dependent child who is:

A. incapable of self sustaining employment by reason of a physically or mentally disabling injury, illness or condition; who became so incapacitated prior to the attainment of the limiting age set forth above, and

B. chiefly dependent upon the Insured for support and maintenance, shall not terminate. Coverage shall continue as long as the certificate remains in force and the dependent is disabled. Proof of such incapacity and dependency must be furnished to Us within sixty (60) of receipt of notice by Us that such coverage will terminate. We will provide such notice at least 90 days prior to the date the Dependent child attains the limiting age. Continued proof may be requested, but not more frequently than once a year.

"Durable Medical Equipment" means medical equipment that can withstand repeated use, is prescribed by a Physician, and is appropriate for use in the home. Covered DME is limited to a standard basic Hospital bed and/or a standard basic wheel chair.

"Effective Date" means the date the Insured's (and Eligible Dependents' if applicable) coverage under the policy is effective.

"Experimental Treatment" means in Our discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.
3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise experimental in nature.

"Extended Care Facility" means an institution, other than a Hospital, operated and licensed pursuant to law, that provides:

1. Permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their illnesses or injuries;
2. Full-time supervision of a Doctor;
3. Twenty-four (24) hour a day nursing service of one or more Nurses; and
4. Is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addiction or alcoholism.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:

1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

"Home Health Care Plan" means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the plan, an attending Doctor must certify that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility.

"Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"Injury" means accidental bodily Injury of a Covered Person:

1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury.

"Inpatient" means a person who incurs medical expenses for at least one day's room and board from a Hospital.

"Insured" means a person who meets the eligibility requirements for an Insured as stated in the Master Application and the policy, and whose coverage under the policy has become effective and has not terminated.

"Medically Necessary" means the care, service or supply is:

1. Prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
2. Appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care, service or supply, is given.

“Mental and Nervous Disorder” means a “biologically-based” mental disorder, including Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, Paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Delirium and dementia, Affective disorders, and any other "biologically-based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the "DSM").

“Outpatient” means a person who incurs medical expenses at Doctor’s offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

“Regular and Customary Activities” means an Insured Person can carry on a substantial part of the standard and commonly practiced activities of a person in good health of the same sex and age. Activities performed while confined in a Hospital or other medical institution may not be used to meet this requirement.

“Routine Physical Exam” means examination of the physical body by a Doctor for preventive or informative purposes only, and not for the diagnosis or treatment of any condition.

“Sickness” means Sickness or disease of a Covered Person that:

1. Is treated by a Doctor while the person is covered under the policy; and
2. Results directly and independently of all other causes in loss covered by the policy.

“Substance Abuse” means the overindulgence in and dependence on a psychoactive leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others.

“Surgery or Surgical Procedure” means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Doctor while the patient is under general or local anesthesia.

“Total Disability” (or “Totally Disabled”) means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, “Totally Disabled” means the inability to perform a majority of the normal activities of a person of like age in good health.

“Urgent Care Center” means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

“Usual and Customary” charges means the following:

1. A usual fee is defined as the charge made for a given service by a Doctor to the majority of his or her patients; and
2. A customary fee is one that is charged by the majority of Doctors within a community for the same services. All benefits are limited to Usual and Customary charges.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Coverage will be effective for an Insured and his Eligible Dependent(s) as of the approved Effective Date, provided:

1. The Insured meets the eligibility requirements set forth in the Master Application and the Policy;
2. The Insured's Application is approved by Us;
3. The first premium payment is received on or before the date the Insured's Application is approved by Us;
4. The Insured is not confined at home or in a Hospital or medical institution as of the Effective date; and
5. The Insured is engaging in his Regular and Customary Activities as of the Effective date.

If the Insured is not engaged in his Regular and Customary Activities or is confined in a Hospital or medical institution on the Effective Date, coverage will begin the first day he can engage in his Regular and Customary Activities and is not confined in a Hospital or medical institution.

The Company will require satisfactory evidence of insurability for each Insured and Eligible Dependent.

Newborn Child Coverage: A child of the Insured born while the policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth together with additional premium must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for Injury and Sickness provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the Insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by the policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.

PART III - TERMINATION OF INSURANCE

Coverage of a Covered Person under the Policy shall automatically terminate on the earliest of the following dates:

1. The date the Coverage Period expires;
2. The first day of the month coinciding with or following the date other hospital, major medical, group health or other medical insurance coverage becomes effective for a Covered Person;
3. The end of the last period for which the last required premium payment was made for the Insured's or Covered Person's insurance;
4. The date a Covered Person receives the Coverage Period Maximum Benefit Amount;
5. The date the Covered Person enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The premium due date that coincides with or next follows the date on which the Insured is no longer eligible;
7. For a Dependent spouse, the first day of the month following the date of divorce or legal separation from the Insured; or
8. The date We specify that the Covered Person's insurance is terminated because of:
   - A. Failure to provide any signed release, consent, assignment or other documents requested by Us;
   - B. Failure to fully cooperate with Us in the administration of the Policy;
   - C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under the Policy; or
   - D. Misuse of the Covered Person's identification card.

At the death of an Insured, all rights and privileges as a Covered Person under the Policy will transfer to the surviving Dependent spouse. The Dependent spouse will then be considered an Insured instead of a Dependent. In the event the Dependent spouse remarries, coverage under the Policy for the Dependent Spouse and Dependent child(ren), if any, will end on the first day of the month following the date of that marriage. If no surviving Dependent spouse, or at the death of a surviving Dependent spouse, all rights and privileges as a Covered Person under the Policy will transfer to each Dependent child, if any, and he will be considered the Insured instead of a Dependent.

If the Insured selected the Pay In Advance option in the Insured's Application and We received all required premium for the Coverage Period, premium will be reimbursed to the Insured for the period of time, if any, between the date coverage terminates in accordance with the above

provisions and the end of that Coverage Period.

Extension of Benefits

If a covered Bodily Injury or Sickness commences while the Policy is in force as to a Covered Person, benefits otherwise payable under the Policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. The date the Total Disability ends;
2. The date when treatment for the Total Disability is no longer required;
3. The date following a time period equal to the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;
4. The date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. The date the Coverage Period Maximum Benefit amount has been reached.

PART IV - PREMIUMS

1. Unless the Pay In Advance option has been chosen, premium due dates for an Insured will be on the Effective Date and then the same date of each following calendar month. If a month has fewer days than the scheduled premium due date, premium will be due on the last day of the month. All insurance shall be charged from and to the premium due date.

2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves collecting earned premiums, or returning unearned premium shall be limited to the six (6) months immediately preceding the date of determination that the adjustment in premium should be made.

3. Premiums shall be payable in advance to Us at Our Home Office.

4. If the Insured has not given written notice to Us that insurance is to be terminated prior to the premium due date, a grace period of thirty-one (31) days beginning from the premium due date will be allowed for any premium after the first premium. If the Insured fails to pay premium before the grace period expires all coverage shall lapse as of the premium due date.

5. The Policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to the Policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

PART V – DESCRIPTION OF MEDICAL EXPENSES

Subject to the Deductible, Coinsurance and other limits set forth in PART X – SCHEDULE OF BENEFITS, the Company will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   - A. Daily room and board and nursing services not to exceed the average semi-private room rate;
   - B. Daily room and board and nursing services in Intensive Care Unit;
   - C. Use of operating, treatment or recovery room;
   - D. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients;
   - E. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   - F. Emergency treatment of a Sickness; however, an additional $250 Deductible will apply to emergency room charges unless the Covered Person is directly admitted to the Hospital as an Inpatient for further treatment of that Sickness.
2. For Surgery at an Outpatient surgical facility, including services and supplies.
3. For charges made by a Doctor for professional services.
4. For charges made by a Doctor for Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual and Customary charge of the primary surgeon. (Standby availability will not be deemed to be a covered charge.).
5. For dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except Durable Medical Equipment as herein defined.
6. For diagnostic testing using radiology, ultrasonographic or laboratory services
(psychometric, intelligence, behavioral and educational testing are not included).
7. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs,
but not the replacement or repair thereof.
8. For reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease:
   - A. to improve function; or
   - B. to create a normal appearance, to the extent possible.
9. Reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also be extended to include surgery on a non-diseased breast to establish symmetry with the diseased breast. As used in this benefit:
   - A. "Mastectomy" means the surgical removal of all or part of a breast as a result of breast cancer.
   - B. "Reconstructive breast surgery" means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty, and mastopexy.

   Coverage for prosthetic devices and reconstructive surgery means any initial or subsequent surgeries, prosthetic devices and any Medically Necessary follow up care.
10. For radiation therapy or treatment and chemotherapy.
11. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
12. For oxygen and other gasses and their administration by or under the supervision of a
Doctor.

13. For anesthetics and their administration by a Doctor, subject to a maximum of 20% of the benefit payable for the primary surgeon.
14. Extended Care Facility charges for room and board accommodations; if:
    A. The Insured is an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;
    B. The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
    C. That confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.
15. Treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Eligible Expenses for Home Health Care are the Maximum Allowable Charges made for the following:
    A. Part-time skilled nursing care;
    B. Physical therapy;
    C. Speech therapy;
    D. Medical supplies, drugs and medicines prescribed by a Doctor;
    E. Laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under the Policy had the Insured Person remained Hospitalized;
    F. Occupational therapy; and
    G. Respiratory therapy. However, benefits will not be paid for charges made by a Home Health Care Agency for:
    A. Any charges excluded under the Exclusions of the certificate;
    B. Full-time nursing care at home;
    C. Meals delivered to the home;
    D. Homemaker services;
    E. Any services of an individual who ordinarily resides in the Insured's home or is a member of the Insured's immediate family; or
    F. Any transportation services.

    Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the certificate.
16. Local Ambulance transport necessarily incurred in connection with Injury, and Local Ambulance transport necessarily incurred in connection with Sickness resulting in Inpatient hospitalization.
17. Dental treatment and dental surgery necessary to restore or replace natural teeth lost or damaged as a result of an Injury covered under this certificate.
18. Medically Necessary rental of Durable Medical Equipment (limited to a standard basic hospital bed and/or a standard basic wheelchair) up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.
19. Physical Therapy if prescribed by a Doctor who is not affiliated with the Physical Therapy practice, necessarily incurred to continue recovery from a covered Injury or Sickness.

Pre-Certification Requirements

1. All hospitalizations, other Inpatient care, and Surgeries or Surgical Procedures must be Pre-certified.
2. To comply with the Pre-certification requirements, the Covered Person must:

A. Contact the Company at 1-866-400-7102 as soon as possible before the expense is to be incurred; and
B. Comply with the instructions of the Company and submit any information or documents they require; and
C. Notify all Doctors, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

3. If the Covered Person complies with the Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions described in this certificate. If the Covered Person does not comply with the Pre-certification requirements or if the expenses are not Pre-certified:
   A. Eligible Medical Expenses will be reduced by 50%; and
   B. The Deductible will be subtracted from the remaining amount; and
   C. The Coinsurance will be applied.
4. Emergency Pre-certification: In the event of an emergency Hospital admission, Pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.
5. Pre-certification Does Not Guarantee Benefits – The fact that expenses are Pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.
6. Concurrent Review – For Inpatient stays of any kind, the Company will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if a Covered Person receives prior approval.

Pre-Certification Requirements for reconstructive surgery in connection with a mastectomy shall not be required in determining length of stay in a hospital following such surgery or procedure. Only a Doctor competent to evaluate the specific clinical issues involved in the care requested, can deny a request to authorize care for reconstructive surgery.

State Mandated Benefits.
The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Period Maximum Benefit amounts shown on the Schedule of Benefits.

1. **Dental Anesthesia** – Coverage shall be provided for general anesthesia for dental care for a Dependent child if an underlying medical condition requires such anesthesia to be provided in a hospital or surgery center setting. Coverage shall only include payment for:
   A. anesthesia; and
   B. hospital or surgery center setting charges.

   The Dependent child must meet the following conditions:
   A. be under the age of seven (7); or
   B. be developmentally disabled, regardless of age; and
   C. it is determined that such child's health is compromised and general anesthesia is Medically Necessary.

2. **Child Preventive Care** - Coverage shall be provided for comprehensive child preventive care consistent with the following for children 16 years of age or younger:
   A. The recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics of September 1987;

B. The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the:
   (a) American Academy of Pediatrics;
   (b) Advisory Committee on Immunization Practices; and
   (c) American Academy of Family Physicians;
   unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this benefit provision. and

C. Include benefits for:
   (a) periodic health evaluations;
   (b) immunizations; and
   (c) laboratory services in connection with periodic health evaluations.

3. **Mammography Screening** - Coverage shall be provided for the screening and diagnosis of breast cancer based on the following:
   A. A baseline mammogram for a woman who is thirty-five (35) to forty (40) years of age;
   B. A mammogram for a woman who is forty (40) to forty-nine (49) years of age, every two years, or more frequently, based on the recommendation of the woman's Doctor;

   C. A mammogram each year for a woman who is at least fifty years (50) of age;

4. **Laryngectomy** - Coverage shall be provided for prosthetic devices to restore speech after a laryngectomy.
   As used here:
   Laryngectomy means the Medically Necessary removal of the larynx.

   Prosthetic devices means initial and replacement prosthetic devices, including installation accessories prescribed by a Doctor. It does not include an electronic voice producing machine.

5. **Prostate Screenings** - Coverage shall be provided for the screening and diagnosis of prostate cancer. Coverage shall include, but not be limited to:
   A. prostate specific antigen testing; and
   B. digital rectal examinations.

   Coverage does not include:
   A. radical prostatectomy;
   B. external beam radiation therapy;
   C. radiation seed implants; or
   D. combined hormonal therapy.

6. **Cervical Cancer Screenings** - Coverage shall be provided for an annual cervical cancer screening test including a Pap test or any cervical cancer screening test approved by the FDA and recommended by a Doctor.

7. **Cancer Screening Tests** - Coverage shall be provided for generally medically accepted cancer screening tests.

8. **Phenylketonuria (PKU) Treatment** - Coverage shall be provided for the testing and treatment of phenylketonuria (PKU). Such coverage will include formulas and special food products that are:
   A. part of a diet prescribed by a Doctor;
   B. managed by a health care professional in consultation with a Doctor who specializes in the treatment of metabolic disease.

   Such diet must be Medically Necessary to avoid the development of a serious physical or mental disability; or to promote normal development or function as a consequence of PKU. Coverage is only required to the extent it exceeds the cost of a normal diet.

   As used here:
   "Formula" means an enteral product for use at home that is prescribed or ordered by a Doctor or other authorized health care provider as Medically Necessary for the treatment of PKU.

   "Special food products" means a food product that is both:
   A. prescribed by a Doctor for the treatment of PKU and consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
   B. used in place of normal food products, such as grocery store foods , used by the general population.

9. **Osteoporosis** - Coverage shall be provided for the diagnosis, treatment and appropriate management of osteoporosis. Coverage will include, but not be limited to, FDA approved technologies such as bone mass measurement, as deemed medically appropriate.

10. **Severe Mental Illness/Serious Emotional Disturbances of a Child** - Coverage for Medically Necessary treatment shall be provided for:
   A. diagnosis and treatment of severe mental illness for a Covered Person of any age; and
   B. emotional disturbances of a child who:
      (a) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to such child's age according to expected development norms; and
      (b) meets one or more of the following:
         (i) displays psychotic features, risk of suicide, or risk of violence due to a mental disorder; or
         (ii) meets special education eligibility requirements pursuant to California state law; or
         (iii) has substantial impairment, as a result of the mental disorder, in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and either of the following occur: the child is at risk of removal from his/her home or has already been removed from the home; or the

mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

Benefits shall include charges incurred for:

1. Outpatient services;
2. Inpatient hospital services, including inpatient prescription drugs and
3. Partial hospital services.

As used here:
"Severe mental illness" shall include:

1. Schizophrenia or schizoaffective disorder; or
2. Bipolar disorder (manic-depressive illness); or
3. Major depressive disorder; or
4. Panic disorder; or
5. Obsessive-compulsive disorder; or
6. Pervasive developmental disorder or autism; or
7. Anorexia nervosa or bulimia nervosa.

11. **Diabetes** - Coverage shall be provided for Medically Necessary supplies, equipment and management and treatment of insulin using diabetes, non-insulin using diabetes and gestational diabetes. Coverage shall include:

A. Blood glucose monitors, including glucose monitors for the visually impaired;
B. Blood glucose test strips, ketone urine testing strips;
C. Insulin pumps and related necessary supplies;
D. Lancets and lancet puncture devices;
E. pen delivery systems for the administration of insulin;
F. Podiatric devices to prevent or treat diabetes related complications;
G. Insulin syringes;
H. Visual aids (but not eyewear) to assist the visually impaired with proper dosing of insulin.

Coverage shall also include outpatient self-management training, education and medical nutrition therapy services necessary to enable the Covered Person to properly use the equipment and supplies listed above. Such services must be provided by an appropriately licensed or registered health care professional as prescribed by a health care professional legally authorized to prescribe the services.

12. **AIDS Vaccine** – Coverage shall be provided for a vaccine for Acquired Immune Deficiency Syndrome (AIDS) that is approved by the FDA and recommended by the U.S. Public Health Service.

13. **Cancer Clinical Trials** - Coverage shall be provided for routine patient costs for a Covered Person diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer. The Covered Person's Doctor must recommend participation in the clinical trial and determine that it will have a meaningful potential benefit. Treatment must be provided in a clinical trial that:

A. involves a drug that is exempt under federal regulations from a new drug application; or
B. is approved by one of the following:
   (a) one of the National Institutes of Health (NIH);

(b) the FDA, in the form of an investigational new drug application;
(c) the U.S. Department of Defense; or
(d) the U.S. Veterans' Administration.

"Routine patient costs" means costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

A. Health care services typically provided absent a clinical trial.
B. Health care services required solely for the provision of the investigational drug, item, device, or service.
C. Health care services required for the clinically appropriate monitoring of the investigational item or service.
D. Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
E. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

It does not include:

A. drugs or devices not approved by the FDA and that are associated with the clinical trial;
B. services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses;
C. any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
D. health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded under this certificate; or
E. health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

PART VI – EXCLUSIONS

Charges for the following treatments and/or services and/or supplies and/or conditions are excluded from coverage:

1. Pre-existing Conditions – Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the six (6) month period immediately preceding such person's Effective Date are excluded for the first six (6) months of coverage hereunder. A Covered Person who was covered under creditable coverage within 63 days of enrolling under this certificate shall be given credit for the period of time under such coverage toward the satisfaction of this exclusion. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this certificate in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE. Creditable Coverage means any of the following:
   - A. A group health plan; or
   - B. Health insurance coverage (care under any hospital or medical service policy or certificate; hospital or medical service plan contract; or Health Maintenance Organization (HMO); or
   - C. Individual coverage; or
   - D. Medicare; or
   - E. Medicaid; or
   - F. CHAMPUS; or
   - G. A medical care program of the Indian Health Service or of a tribal organization; or
   - H. A State health benefits risk pool; or
   - I. A health plan offered under the Federal Employees Health Benefits Program (FEHBP); or
   - J. A public health plan; or
   - K. A health benefit plan under the Peace Corps Act.

   Creditable coverage does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, workers' compensation insurance or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

   Any coverage under which an insured was covered prior to a break in coverage of 63 consecutive days or more, not counting any waiting period or affiliation period required by any Creditable Coverage, will not be considered Creditable Coverage.
2. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
3. Routine pre-natal care, Pregnancy, childbirth, and postnatal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
4. Alcoholism.
5. Substance abuse.
6. Charges which are not incurred by a Covered Person during his/her Coverage Period.
7. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor.
8. Treatment, services or supplies which are not Medically Necessary as defined.
9. Treatment, services or supplies provided at no cost to the Covered Person.

10. Charges which exceed Usual and Customary charge as defined.
11. Telephone consultations or failure to keep a scheduled appointment.
12. Consultations and/or treatment provided over the Internet.
13. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.
14. All charges Incurred while confined primarily to receive Custodial or Convalescence Care.
15. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
17. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this certificate.
18. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
19. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
20. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
21. Dental treatment, except for dental treatment that is expressly covered under this certificate.
22. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
23. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
24. Treatment for cataracts.
25. Treatment of the temporomandibular joint, except for medically necessary surgical procedures for covered conditions directly affecting the upper or lower jawbone or associated bone joints.
26. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultra light gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting.
27. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports.
28. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.
29. Willfully self-inflicted Injury or Sickness.
30. Immunizations and Routine Physical Exams, except as expressly covered under this certificate or under a Rider attached to this certificate.
31. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.
32. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.

33. Any services performed or supplies provided by a member of the Insured's Immediate Family.
34. Orthoptics and visual eye training.
35. Services or supplies which are not included as Eligible Expenses as described herein.
36. Care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
37. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
38. Treatment of sleep disorders.
39. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs.
40. Any services or supplies in connection with cigarette smoking cessation.
41. Exercise programs, whether or not prescribed or recommended by a Doctor.
42. Treatment required as a result of complications or consequences of a treatment or condition not covered under this certificate.
43. Charges for travel or accommodations, except as expressly provided for local ambulance.
44. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
45. Organ or Tissue Transplants or related services.
46. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.
47. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
48. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this certificate.
49. Spinal manipulation or adjustment.
50. Sclerotherapy for veins of the extremities.
51. Expenses during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion):
    A. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
    B. Tonsillectomy;
    C. Adenoidectomy;
    D. Repair of deviated nasal septum or any type of surgery involving the sinus;
    E. Myringotomy;
    F. Tympanotomy;
    G. Herniorrhaphy; or
    H. Cholecystectomy.
52. Chronic fatigue or pain disorders.
53. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
54. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
55. Kidney or end stage renal disease.
56. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.

57. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
58. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

PART VII – COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any coverage year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance or accidental death and dismemberment benefits.

The term "plan" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "plan" also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid.

Definitions. "Plan" – means any of the following which provides benefits or services for medical expenses:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

Each contract or other arrangement for coverage under the above paragraphs is a separate plan. Also, if an arrangement has two parts and COB rules apply to one of the two, each of the parts is construed to mean a separate Plan.

The term "plan" does not include:

1. Individual or family insurance or subscriber contracts;
2 Individual or family coverage through Health Maintenance Organizations (HMOs);
3. Individual or family coverage under other prepayment, group practice and individual practice plans;
4. School accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a to-and-from school basis);
5. Group or group-type hospital indemnity benefits of $100 per day or less;
6. Medicare Supplement policies;
7. A state plan under Medicaid.

"Primary Plan (Primary)" – means the Plan which determines its benefits before those of the other Plan. When there are more than two (2) Plans, This Plan may be Primary as to one and Secondary as to another.

"Secondary Plan (Secondary)" – means the Plan which determines its benefits after those of the other Plan. When there are more than 2 Plans, This Plan may be Secondary as to one and Primary as to another.

"This Plan" – means the benefits provided under this group policy.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If the Primary Plan's payment is less than the charge for the allowable expense, then the Secondary Plan will apply its benefit payment to the balance.
The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the Primary Plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
   A. First, benefits of a plan covering persons as an employee, member, or subscriber.
   B. Second, benefits of a plan of an active worker covering persons as a dependent.
   C. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
   A. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
   B. If both parents have the same birthday the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
   C. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
   D. When the parents are separated or divorced and the parent with custody has not remarried the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   E. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
   F. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary

insured's dependent. This rule will not apply if the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   A. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   B. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6 When rules 2 through 5 do not establish an order of benefit determination the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by us we have the right to pay the other plan any amount we deem necessary to satisfy our obligation under these COB rules.

Right of Recovery. If the amount of our benefit payment is more than the amount needed to satisfy our obligation under these COB rules, we have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as we deem necessary; and
2. Any person claiming benefits under this plan must give us any information necessary to carry out this provision.

PART VIII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins or as soon as is reasonably possible. The notice must be given to the Company named on the Schedule of Benefits. Notice should include information that identifies the claimant and the policy.

Claim Forms: When the Company receives notice of claim, forms for filing proof of loss will be sent to the claimant. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

1. In writing;
2. Setting forth the nature and extent of the loss; and
3. Within the time stated in the Proof of Loss provision.

Proof of Loss: Written proof of loss must be given to the Company within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Company within one year after it is due unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss, but no later than 30 working days after We receive Proof of Loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to $1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

Third Party Liability: No benefits are payable for any Sickness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Company will advance the benefits of this policy to the Insured subject to the following:

1. The Insured agrees to advise Us, in writing, within 60 days of any Covered Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as We may require to facilitate enforcement of the claim. The Insured and Covered Person also agree to take no action that may prejudice Our rights or interests under this policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this policy and will result in the Insured being personally responsible for reimbursing Us.

2 We will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Covered Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this policy for the treatment of the Sickness, disease, Injury or condition for which the third party is liable.

Independent Medical Review: A Covered Person, or a representative acting on his or her behalf, has the right to request an independent medical review whenever healthcare services have been denied, modified or delayed by Us, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. A doctor, or other health care provider, may assist in seeking an independent medical review and may advocate on such Covered Person's behalf.

PART IX – GENERAL PROVISIONS

Time Limit on Certain Defenses: The validity of coverage issued under the Policy with respect to an Insured or his Eligible Dependents may not be contested after three years from each certificate's effective date, except for nonpayment of premiums.

Misstatement of Age: If the age of any Covered Person is incorrectly stated, we will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had we known the correct information.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Pronouns: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

PART X – SCHEDULE OF BENEFITS

INSURED INFORMATION:
Name:

Policy Effective Date:

COVERAGE PERIOD:

ELIGIBILE DEPENDENTS COVERED

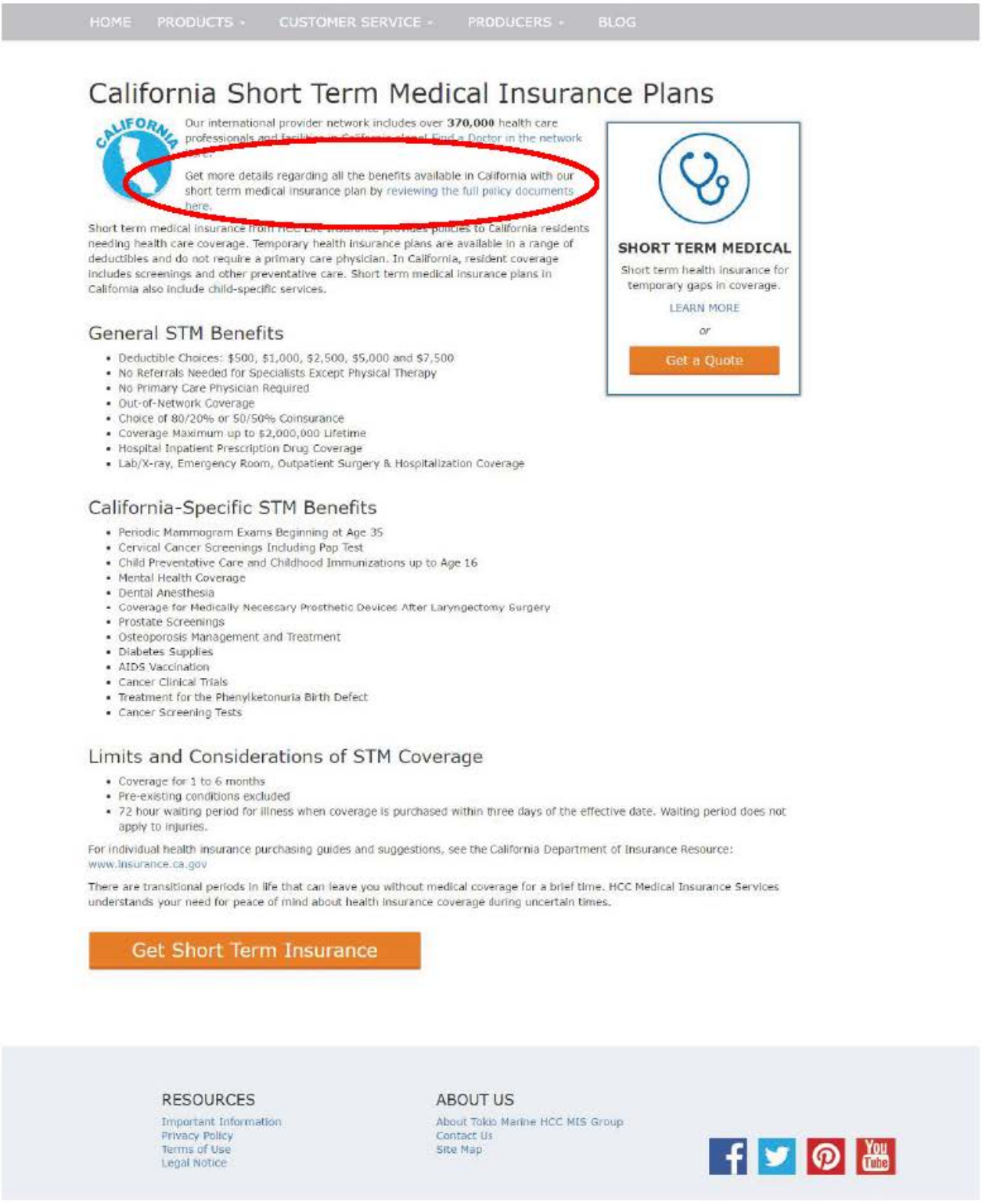
COVERAGE AND BENEFIT AMOUNTS:

Deductible	per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period. An additional Deductible of $250 per visit will be applied to charges for use of emergency room in the event of Sickness unless the Covered Person is directly admitted as an Inpatient for further treatment.
Coinsurance	During a Coverage Period, the Company will pay of the next $5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.
Urgent Care Center	For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible
Hospital Room and Board	Average Semi-private room rate, including nursing services.
Local Ambulance	Injury: Usual and Customary charges to a Maximum of $250 per trip, when related to a covered Injury. Sickness: Usual and Customary charges to a maximum of $250 per trip, when covered Sickness results in hospitalization as Inpatient
Intensive Care Unit	Usual and Customary charges
Physical Therapy	$50 Maximum per visit per day
Home Health Care	Maximum 1 visit per day. Maximum of 40 visits during a Coverage Period
Extended Care Facility	Not to exceed a daily rate of $150 nor a maximum of 60 days

All Other Eligible Medical Expenses	Usual and Customary charges
Penalty for Failure to Pre-certify	50% of Eligible Medical Expenses
Overall Maximum Limit per Coverage Period	

EXHIBIT 8

Exhibit 8



HOME PRODUCTS CUSTOMER SERVICE PRODUCERS BLOG

California Short Term Medical Insurance Plans

Our international provider network includes over **370,000** health care professionals and facilities in California. Find a Doctor in the network near you.

Get more details regarding all the benefits available in California with our short term medical insurance plan by reviewing the full policy documents here.

Short term medical insurance from HCC Life Insurance provides policies to California residents needing health care coverage. Temporary health insurance plans are available in a range of deductibles and do not require a primary care physician. In California, resident coverage includes screenings and other preventative care. Short term medical insurance plans in California also include child-specific services.

SHORT TERM MEDICAL

Short term health insurance for temporary gaps in coverage.

LEARN MORE

or

Get a Quote

General STM Benefits

- Deductible Choices: $500, $1,000, $2,500, $5,000 and $7,500
- No Referrals Needed for Specialists Except Physical Therapy
- No Primary Care Physician Required
- Out-of-Network Coverage
- Choice of 80/20% or 50/50% Coinsurance
- Coverage Maximum up to $2,000,000 Lifetime
- Hospital Inpatient Prescription Drug Coverage
- Lab/X-ray, Emergency Room, Outpatient Surgery & Hospitalization Coverage

California-Specific STM Benefits

- Periodic Mammogram Exams Beginning at Age 35
- Cervical Cancer Screenings Including Pap Test
- Child Preventative Care and Childhood Immunizations up to Age 16
- Mental Health Coverage
- Dental Anesthesia
- Coverage for Medically Necessary Prosthetic Devices After Laryngectomy Surgery
- Prostate Screenings
- Osteoporosis Management and Treatment
- Diabetes Supplies
- AIDS Vaccination
- Cancer Clinical Trials
- Treatment for the Phenylketonuria Birth Defect
- Cancer Screening Tests

Limits and Considerations of STM Coverage

- Coverage for 1 to 6 months
- Pre-existing conditions excluded
- 72 hour waiting period for illness when coverage is purchased within three days of the effective date. Waiting period does not apply to injuries.

For individual health insurance purchasing guides and suggestions, see the California Department of Insurance Resource: www.insurance.ca.gov

There are transitional periods in life that can leave you without medical coverage for a brief time. HCC Medical Insurance Services understands your need for peace of mind about health insurance coverage during uncertain times.

Get Short Term Insurance

RESOURCES

Important Information
Privacy Policy
Terms of Use
Legal Notice

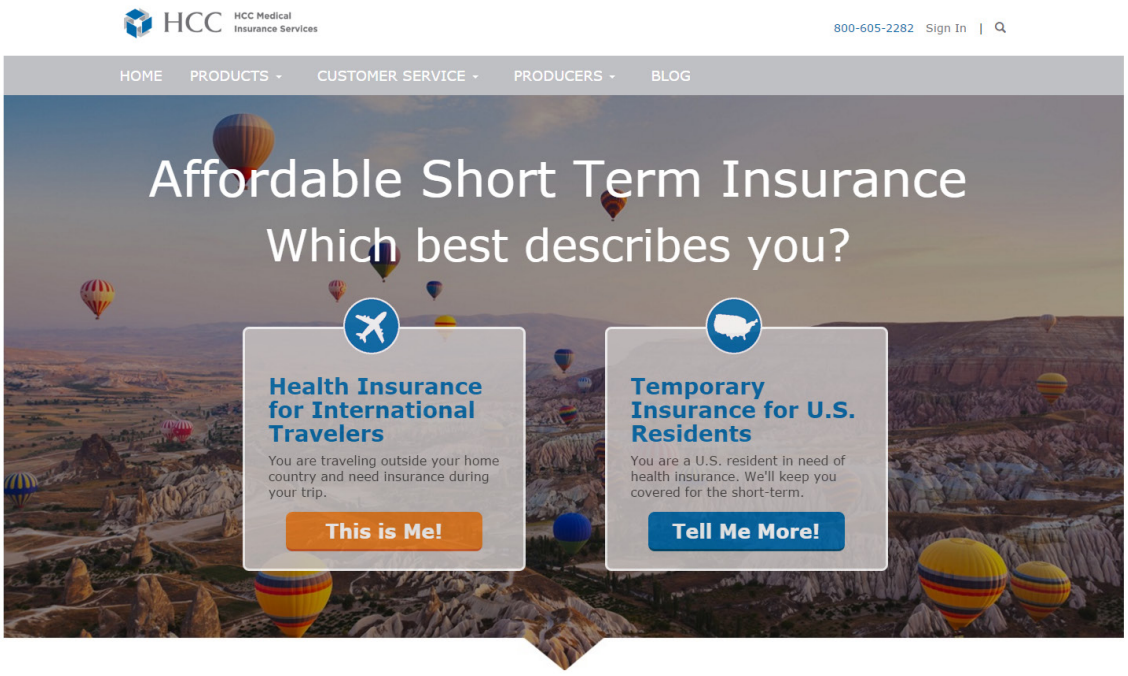
ABOUT US

About Tokio Marine HCC MIS Group
Contact Us
Site Map

EXHIBIT 9

Exhibit 9

Step One:



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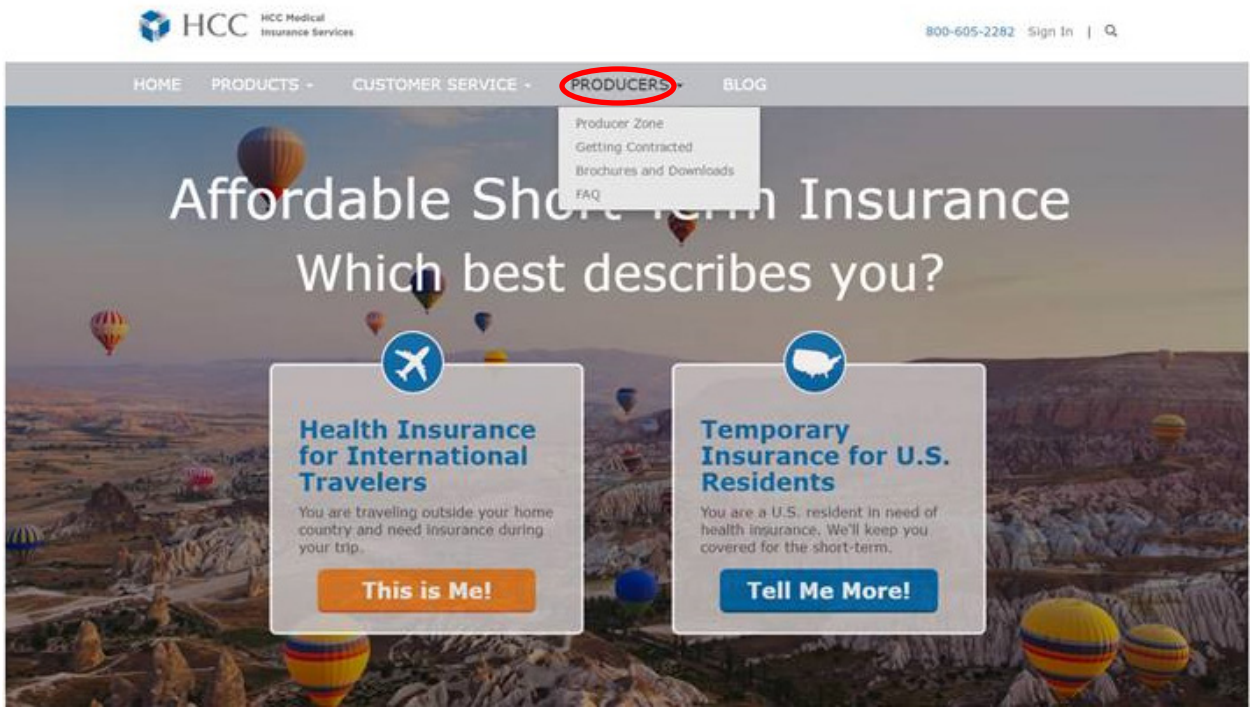

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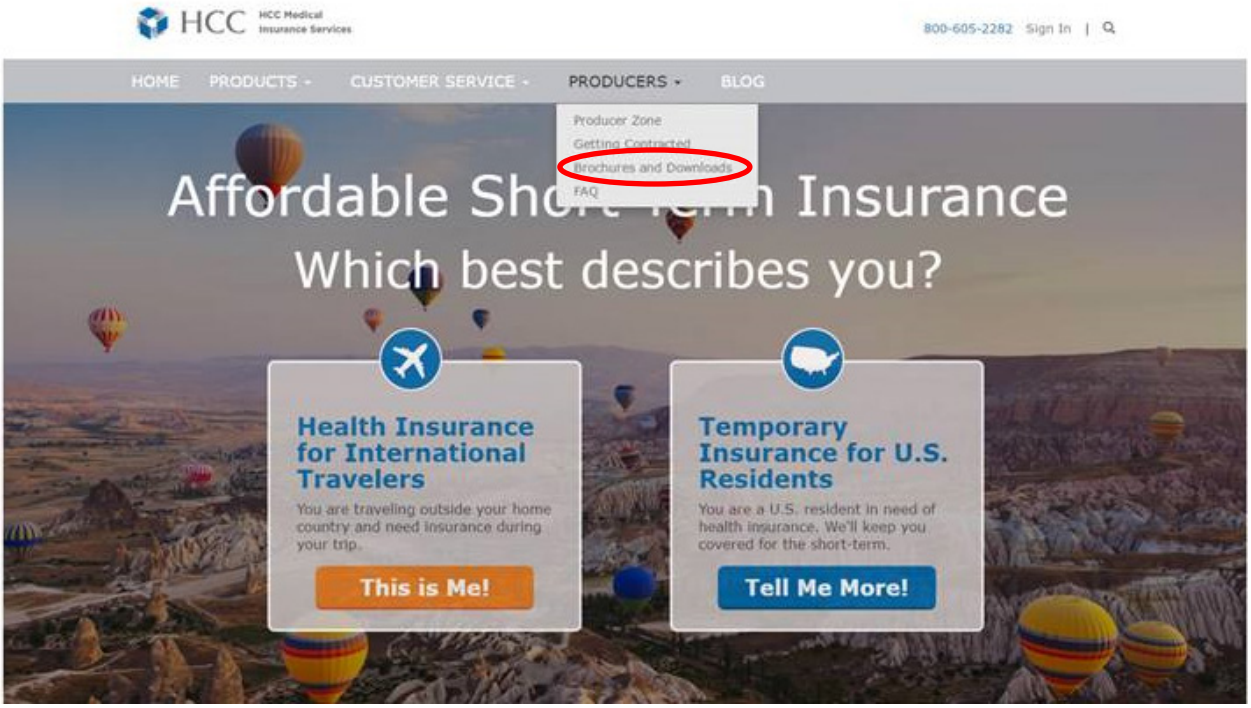

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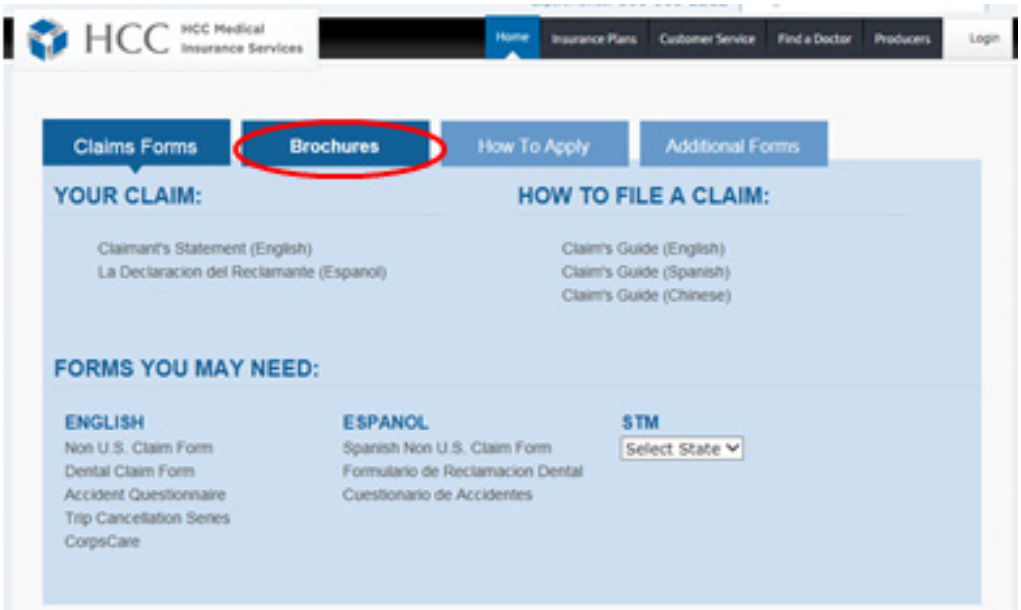

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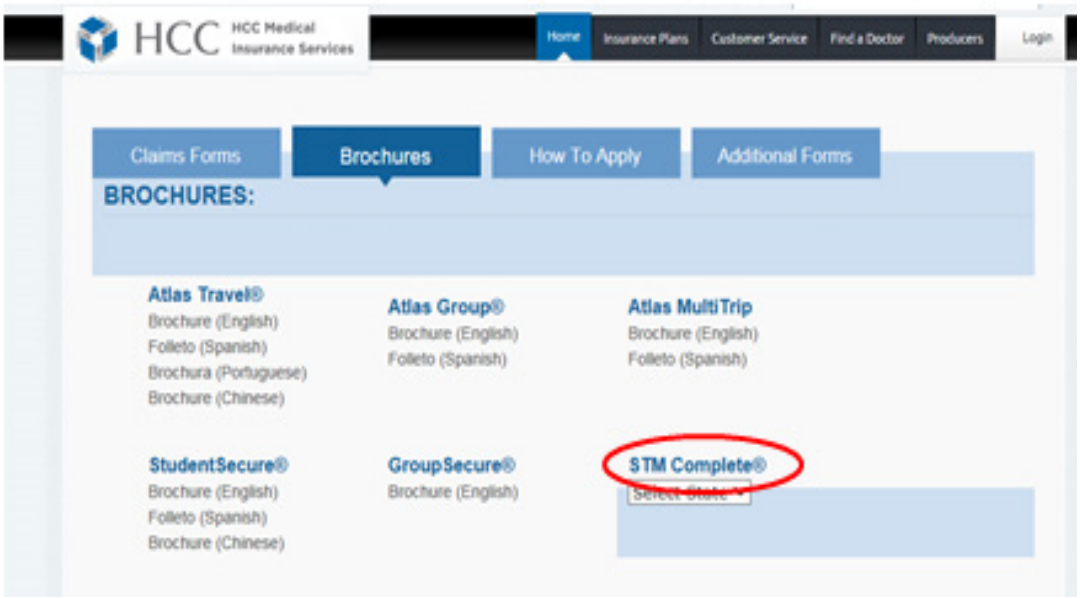

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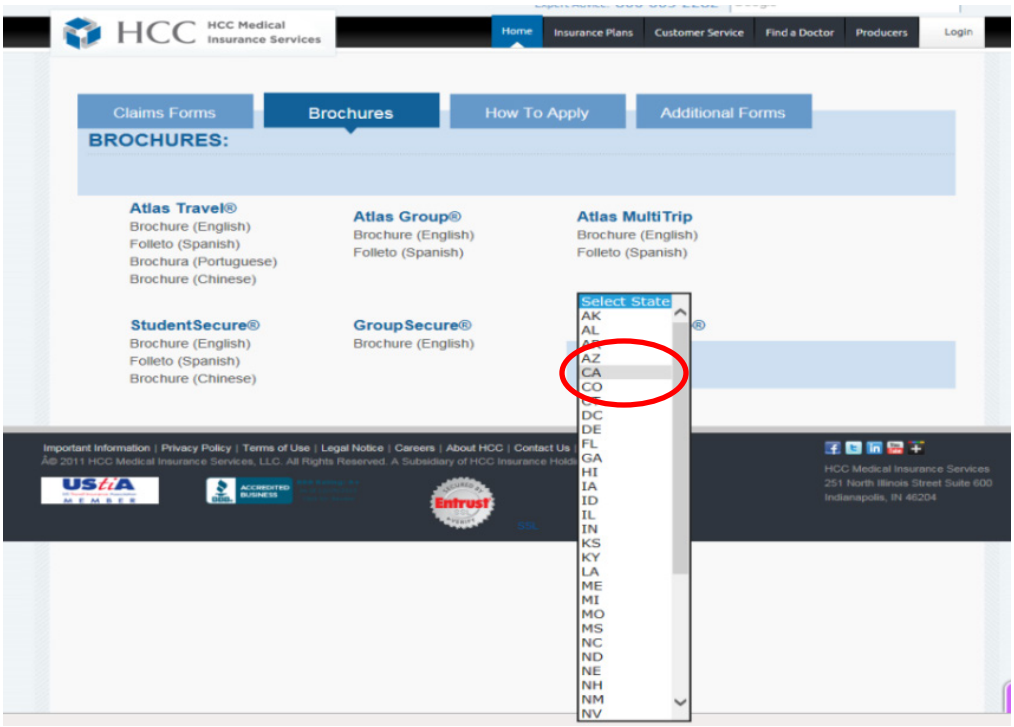

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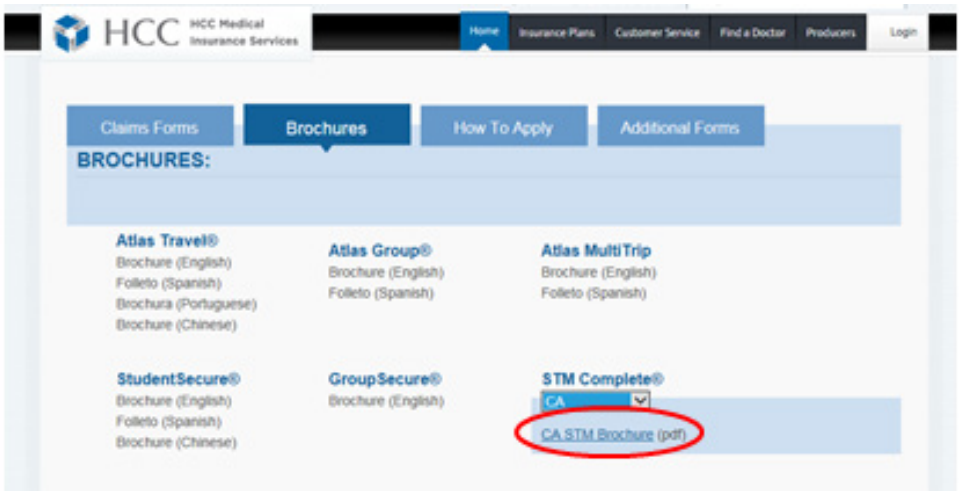
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HCC Medical Insurance Services
Home
Insurance Plans
Customer Service
Find a Doctor
Producers
Login
Claims Forms
Brochures
How To Apply
Additional Forms
BROCHURES:
Atlas Travel®
Brochure (English)
Folleto (Spanish)
Brochura (Portuguese)
Brochure (Chinese)
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CA
CA STM Brochure (pdf)

EXHIBIT 10

Exhibit 10

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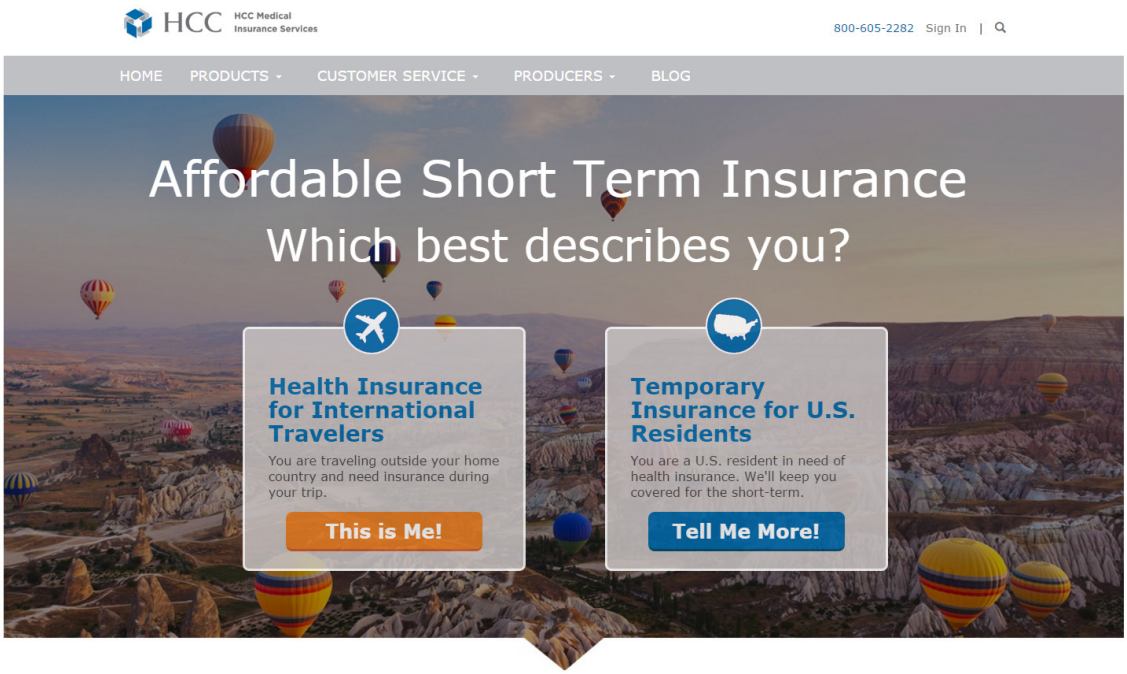

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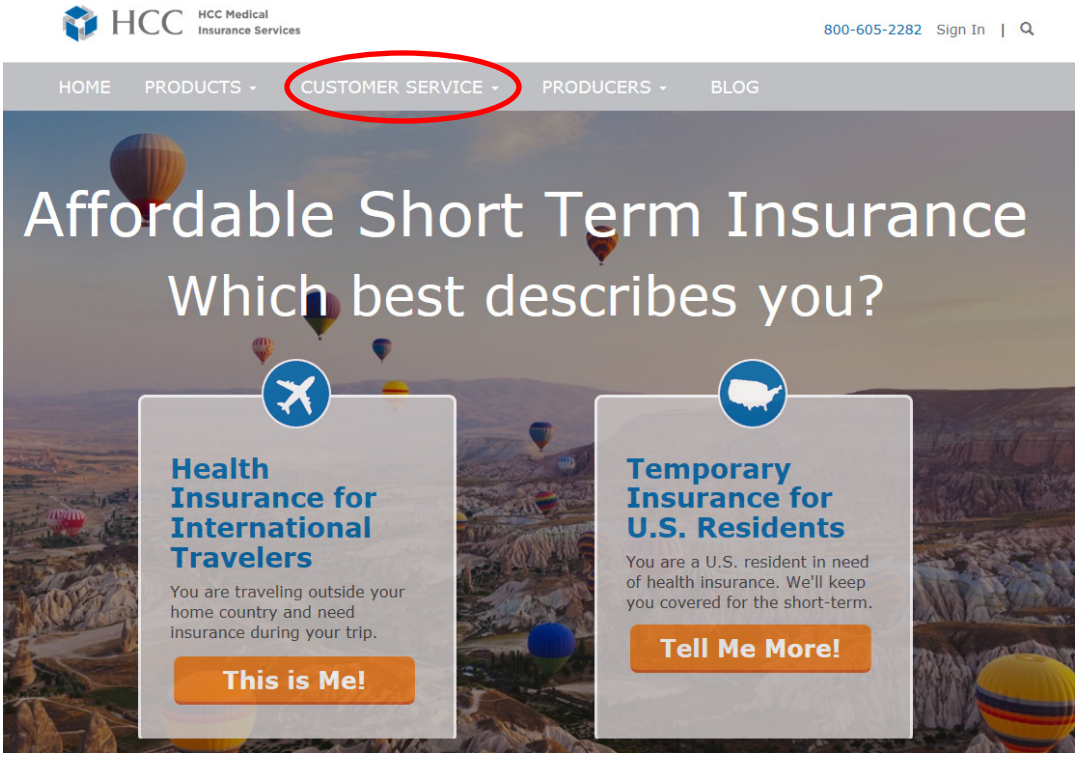

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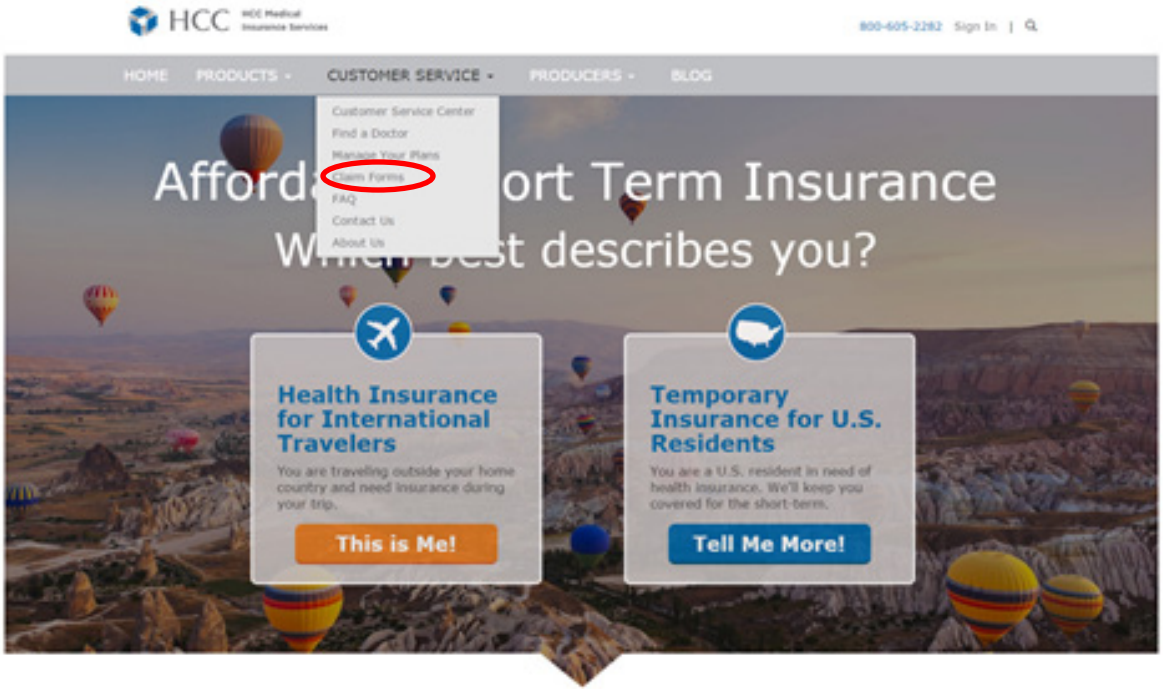

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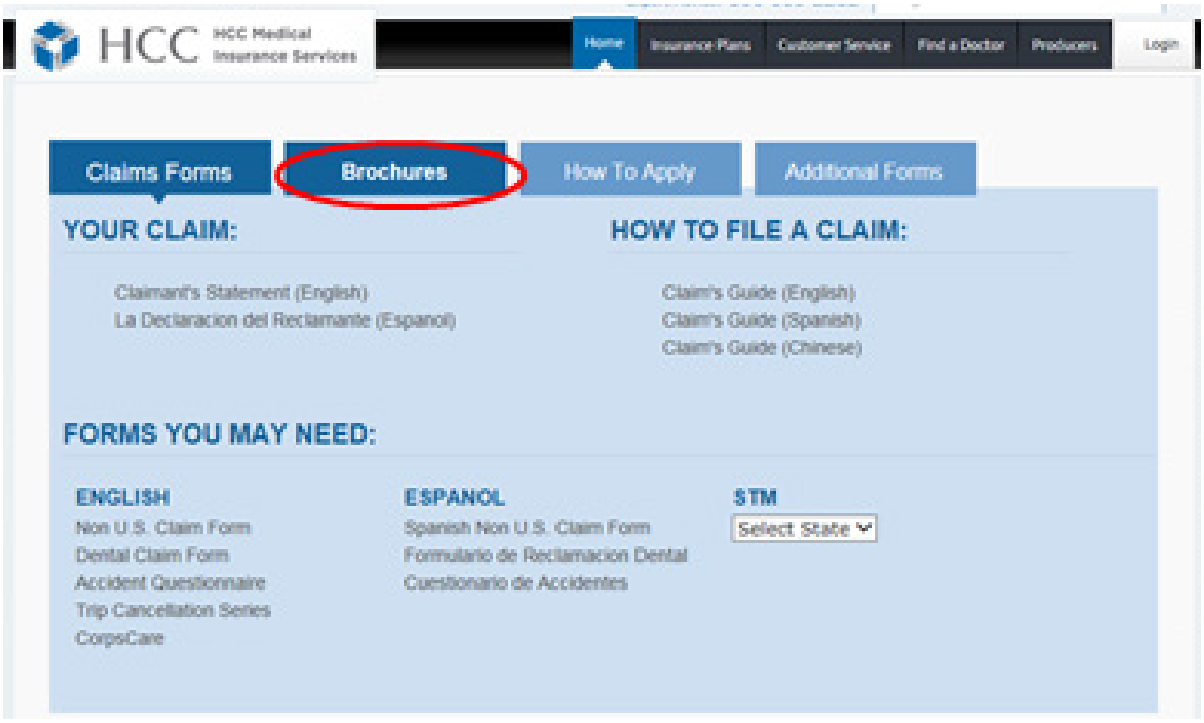

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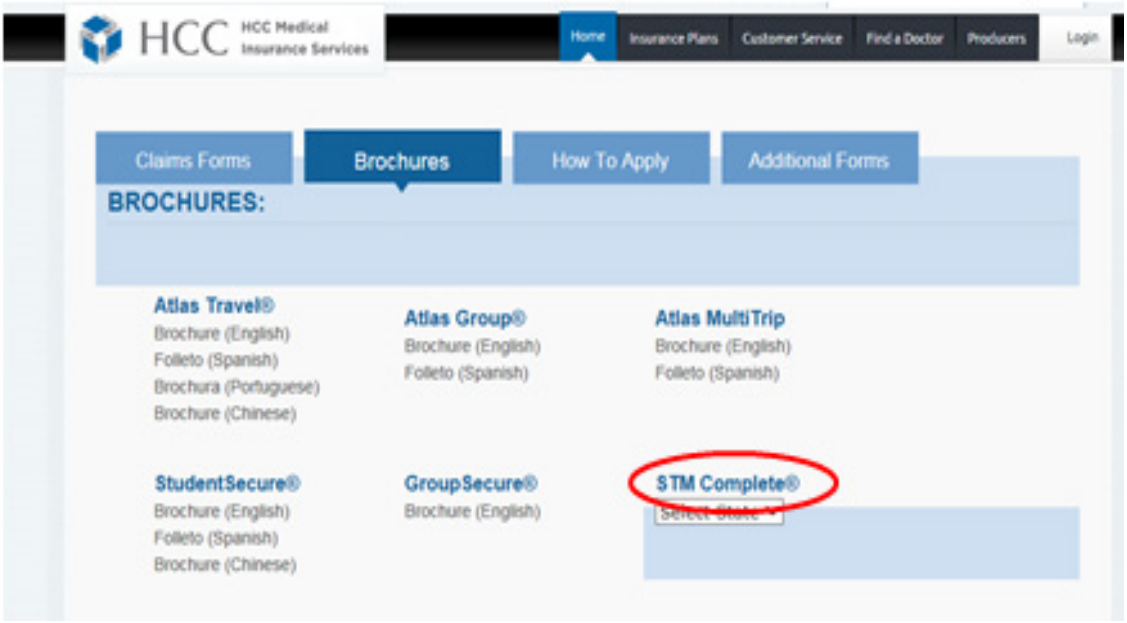

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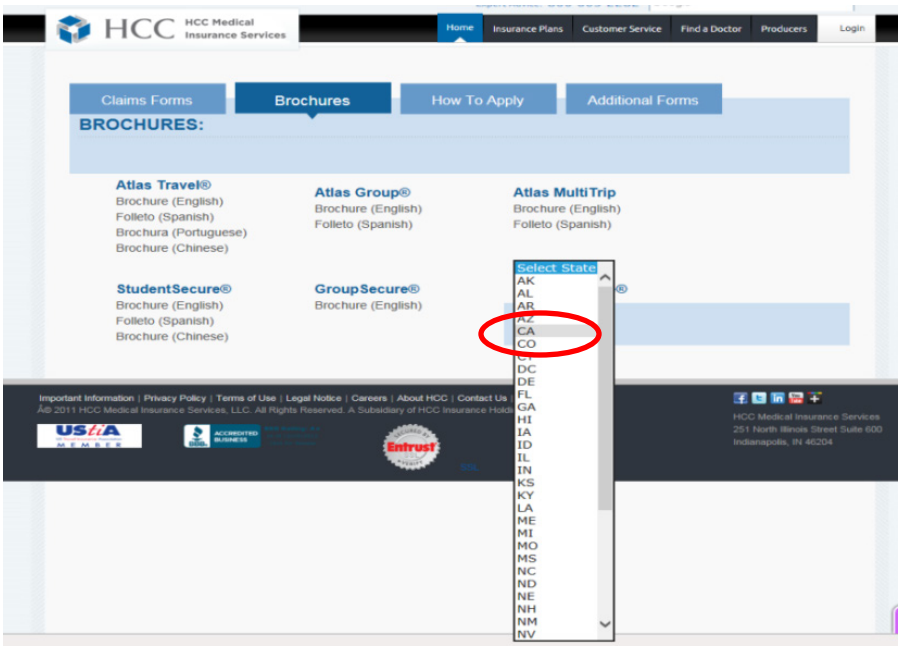

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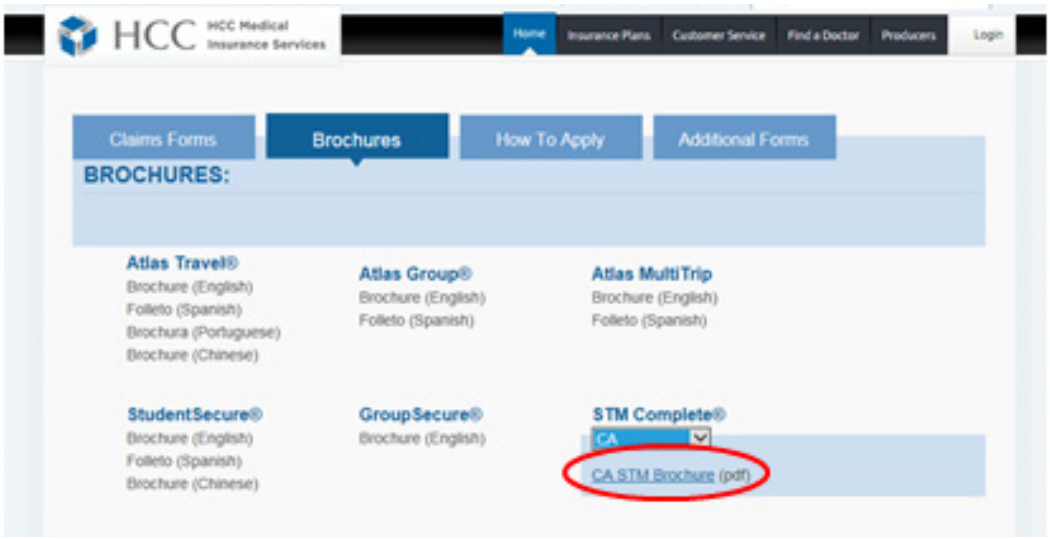
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Claims Forms
Brochures
How To Apply
Additional Forms
BROCHURES:
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Folleto (Spanish)
Brochura (Portuguese)
Brochure (Chinese)
Atlas Group®
Brochure (English)
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Atlas MultiTrip
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Folleto (Spanish)
Brochure (Chinese)
GroupSecure®
Brochure (English)
STM Complete®
CA
CA STM Brochure (pdf)

EXHIBIT 11

HCC Life Short Term Medical

TRANSITIONING BETWEEN JOBS

NEW EMPLOYEES

WAITING FOR MEDICARE COVERAGE

RECENT GRADUATES

HCC

HCC Life Insurance Company

Why Choose HCC Life Short Term Medical?

Waiting for major medical

Cobra substitute

Recently naturalized U.S. citizens

HCC Life Short Term Medical (STM) provides affordable temporary health insurance to protect you and your family. You should consider purchasing HCC Life STM if you are concerned about protecting yourself from the potentially high medical costs associated with an unexpected sickness or injury.

With HCC Life Short Term Medical you are in control. You get to choose your deductible, coinsurance, maximum coverage amount, and the exact length of coverage. You also have the freedom to receive treatment from doctors and hospitals of your choice without incurring out of network penalties. HCC Life Short Term Medical gives you peace of mind.

For more information about HCC Life Short Term Medical, please visit hccmis.com

After purchasing coverage, how can I trust the company to be there if I need them?

For more than 30 years, HCC Life Insurance Company has been leading the way in medical stop loss insurance for employers who self-fund their employee benefit plans. HCC Life's products, including medical stop loss, HMO reinsurance, medical excess, group term life insurance and short term medical insurance are backed by the financial stability of its parent company, HCC Insurance Holdings, Inc. (NYSE: HCC). HCC Life holds a financial strength rating of AA (Very Strong) by Standard & Poor's and Fitch Ratings and A+ (Superior) by A.M Best Company.

Benefits of HCC Life Short Term Medical

Length of Coverage	Up to 6 or 11 months. Purchase in full or make monthly payments.
Deductibles	$250, $500, $1000, $25,00, $5000, or $7500 A maximum of 3 deductibles is required per family
Coinsurance	80% or 50% of the next $5,000 of eligible medical expenses
Coverage Period Maximum	$1 million or $2 million

How HCC Life Short Term Medical Works

Policy benefits are subject to the deductible and coinsurance. After you satisfy your deductible, HCC Life STM will begin paying eligible expenses according to the coinsurance you select and up to the coverage period maximum that you choose. Benefits are based on usual and customary charges of the geographical area in which charges are incurred.

Urgent Care Center

The deductible is waived when you receive care at an urgent care center, and instead you pay a $50 co-payment, after which coinsurance applies. An urgent care center means a facility separate from a hospital emergency department where patients can be immediately treated for injury or sickness on a walk-in basis without an appointment.

HCC Life Short Term Medical Covers:

- Inpatient and outpatient charges made by a hospital, including inpatient prescription drugs
- Charges incurred at an urgent care center after a $50 co-pay
- Charges made by a physician, surgeon, radiologist, anesthesiologist, and any other medical specialist to whom the physician has referred the case
- Charges made for dressings, sutures, casts or other supplies prescribed by the attending physician or specialist, but excluding nebulizers, oxygen tanks, diabetic supplies and all devices for repeat use at home
- Charges for diagnostic testing using radiology ultrasonographic or laboratory services
- Charges for oxygen and other gases and anesthetics and their administration
- Charges made by a licensed extended care facility upon direct transfer from an acute care hospital
- Emergency local ambulance transport in connection with injury or sickness resulting in inpatient hospitalization
- Expenses related to complications of pregnancy
- Charges for physical therapy that is prescribed in advance by a physician in relation to a covered injury or sickness

Eligibility and Enrollment for HCC Life Short Term Medical

Coverage Effective Date

For enrollment forms received online, by e-mail, or by fax, your coverage becomes effective at 12:01 a.m.* on the date following the date we receive your completed application form provided payment has been received. For application forms submitted by mail, your effective date is 12:01 a.m.* on the postmark date of your completed application form or 12:01 a.m.* on the requested effective date, whichever is later, provided payment has been received. Your requested effective date must be within 45 days from the date you signed the application form.*

*Times expressed are based on the geographical area where the policy holder resides.

HCC Life STM Eligibility**

You are eligible to apply for HCC Life STM if you are age 2 through 64 and you meet the following requirements:

1. You are not pregnant, an expectant father, or planning on adopting.
2. You will not be covered by other medical insurance at time of requested effective date.
3. You are not a member of the armed forces of any country, state, or international organization, other than on reserve duty for 30 days or less; and
4. You are able to answer “no” to the medical questions on the application form.

**Your spouse under age 65 and dependents under age 19 are also eligible for coverage, provided they meet the same requirements. Unmarried children under age 25 may also be included as a covered dependent if enrolled full-time in an accredited school or college. Eligibility for children ages 19 through 25 may vary by state. In order to receive coverage, applicant may be required to enroll in the Consumer Benefits of America Association.

Purchasing HCC Life Short Term Medical

HCC Life STM is offered through a nationwide network of independent insurance agents contracted with HCC Medical Insurance Services (HCCMIS). To purchase HCC Life STM, an application form must be completed. Application forms may be submitted via mail, fax or online.

If you apply online, your initial payment must be made by credit card (Visa, American Express, Discover or MasterCard). If application is by mail, you may submit premium via personal check or credit card. Payment options include single up-front or monthly payments.

Purchasing an Additional Policy

HCC Life STM is not renewable, but if your temporary insurance need continues beyond the coverage period purchased, you may apply for a new policy as long as you have not had more than two HCC Life STM policies during the past 12 months. Additional purchase may not be available in some states.

Free Look Period

If you are not 100% satisfied with HCC Life STM, return the certificate along with a written request for cancellation to HCC Life within 10 days of receipt. Coverage will be cancelled as of the effective date. No questions asked!

Consumer Benefits of America

In most states, HCC Life STM is available to members of the Consumer Benefits of America Association. Membership in the association will entitle you to discounts of up to 40% off regular retail prices on many short-term and long-term prescription drugs. Discounts are available from over 59,000 participating pharmacy providers nationwide or by mail service. When membership is required, association fees are assessed at the time of application; enrollment in the association is automatic upon payment of the correct premium and all applicable

HCC Life Insurance Company respects individual privacy and values the confidence of its customers, employees, consumers, business associates, and others. Please contact us or visit our website to obtain a full version of our Privacy Policy.

5000-STM-628-8966

HCC Life Insurance Company 251 North Illinois Street, Suite 600, Indianapolis, IN 46204 main (800) 605 2282 facsimile (317) 262 2140 hccmis.com
A subsidiary of HCC Insurance Holdings, Inc. hcc.com

EXHIBIT 12

HCC Life STM Enrollment Form

For use in CA

HCC Life Insurance Company

(Herein referred to as HCC Life)

Please submit completed applications with payment to:

HCC Life Insurance Company
251 N. Illinois Street, Suite 600
Indianapolis, IN 46204

- Please complete this application entirely. Failure to provide complete information may delay processing.
- You may elect the $5,000 and $7,500 deductible options by applying online or contacting us.

Personal Details Please provide the following details for all individuals to be covered.

Name (First and Last)	Date of Birth	Gender	Contact Information
Primary MOHOMMED AZAD	01-14-[redacted]	✔ Male Female	Address [redacted]
Spouse		Male Female	City [redacted] State [redacted] Zip [redacted]
Child 1		Male Female	Phone Number [redacted]
Child 2		Male Female	E-mail Address [redacted]

Plan Options Please check the boxes corresponding to your elections for deductible and coinsurance.

Deductible	$250	$500	$1,000	✔ $2,500	$5,000	$7,500
Coinsurance	✔ 80% of $5,000		50% of $5,000			
Requested Effective Date	12 / 09 / 2015					

Payment Option

✔ Monthly – 6 month plan

Single Up Front (please specify term date)
Specify Term Date _____
Number of days (max 180) _____

Medical Questions Please answer the questions below as they apply to the Applicant (Primary person listed above) applying for coverage. For each family member applying for coverage, complete and answer the questions on the Dependent Medical Questionnaire.

1. Will you have other health insurance in force on the policy effective date or be eligible for Medicaid?	Yes ✔ No
2. Have you: a. Been denied insurance due to any health reasons for a condition that is still present? b. Now pregnant, in process of adoption or undergoing infertility treatment? c. Over 300 pounds if male or over 250 pounds if female?	Yes ✔ No
3. Within the last 5 years have you been diagnosed, treated, or taken medication for any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?	Yes ✔ No
4. Within the last 5 years have you been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)?	Yes ✔ No
5. If you are not a US Citizen, do you expect to legally reside in the US for the duration of the policy?	Yes No ✔ US citizen

If you have answered "Yes" to questions 1 through 4 or "No" to question 5 above, coverage cannot be issued. Thank you for your interest.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For product information or assistance with this enrollment form, please contact:

Rate Calculation

Use the rate table corresponding to your choice of plan option and coinsurance level to complete applicant rates below, then follow the calculation instructions.

			Monthly Payments	Single Up-front Payment
A	Applicant's Rate		A 46.60	A
B	Spouse's Rate		B 0.00	B
C	Per child 0.00 x # 0 =		C 0	C
D	A + B + C =		D 46.6	D
E	Zip Code Factor		E 2.395	E
F	D x E = Monthly / Daily Premium Total (round to the nearest penny)		F 111.61	F
G	Monthly / Daily Association Fee		G 5.00	G
H	F + G = Total Monthly / Daily Rate		H 116.61	H
I	Number of **Days** to be Covered		**n/a**	I
J	H x I =		**n/a**	J
K	Administrative Fee		K 10.00	K
L	**Total Due**	**Monthly:** H + K= **Daily:** J + K =	L $126.61	L

Payment Information

Please provide complete payment information. Applications without payment cannot be processed.

Check/Money Order (Single Up-Front Payment Only) **MasterCard** ✔ **VISA** **Discover** **American Express**

Credit Card Number	Exp Date
**********6645	06-2018

Name on Card
MOHOMMED AZAD

Phone # [redacted]

Billing Address (including city, state and zip)
[redacted]

Check or Money Orders should be made payable, in US dollars, to HCC Life Insurance Company. If paying by credit card, I authorize HCC Life to debit my Discover, VISA, MasterCard or American Express account for the amount specified in the Rate Calculation section. If I have selected a monthly plan, I hereby request and authorize HCC Life to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for the duration of the Coverage Period elected or until revoked by me in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

Cardholder Signature	Date
MOHOMMED AZAD- Phone Sale	12/08/2015

Authorization

I hereby request coverage under the insurance issued to the Consumer Benefits of America Association and underwritten by HCC Life Insurance Company. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I agree that coverage will not become effective for me or any dependent whose medical status, prior to the effective date, has changed and therefore results in a "yes" answer to any of the medical questions on this application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. I understand that if I have elected the Monthly Payment option, my credit card will be charged each month on the due date of the premium for 6 months, depending on the plan I have selected. I understand that I may terminate the scheduled payments by notifying HCC Life in writing at least one business day prior to the next scheduled payment date. I understand that this coverage is not renewable or extendable. I understand that the information contained herein is a summary of the coverage offered in the Certificate of Insurance and that I may obtain a complete copy of the Certificate of Insurance upon request to HCC Life. I understand that HCC Life, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand and agree that the insurance agent/broker, if any, assisting with this application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned represents his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned represents his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant. If I am not already a member of the Consumer Benefits of America Association, I hereby request to be enrolled as a member. I will receive a membership packet after my membership fees of $5 per month are received. Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Applicant Signature	Date	Spouse Signature	Date
MOHOMMED AZAD	12-08-2015		

Signed by HCC Life Appointed Agent:	Plan Administrator Use Only:	
Zachary Zimmerman	PBC 6CA.110.07.09	Code:

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2. Have you: a. Been denied insurance due to any health reasons for a condition that is still present? b. Now pregnant, in process of adoption or undergoing infertility treatment? c. Over 300 pounds if male or over 250 pounds if female?	Yes ✔ No
3. Within the last 5 years have you been diagnosed, treated, or taken medication for any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?	Yes ✔ No
4. Within the last 5 years have you been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)?	Yes ✔ No
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D	A + B + C =		D 46.6	D
E	Zip Code Factor		E 2.395	E
F	D x E = Monthly / Daily Premium Total (round to the nearest penny)		F 111.61	F
G	Monthly / Daily Association Fee		G 5.00	G
H	F + G = Total Monthly / Daily Rate		H 116.61	H
I	Number of **Days** to be Covered		**n/a**	I
J	H x I =		**n/a**	J
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Name on Card
MOHOMMED AZAD

Phone # [redacted]

Billing Address (including city, state and zip)
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Applicant Signature	Date	Spouse Signature	Date
MOHOMMED AZAD	12-08-2015		

Signed by HCC Life Appointed Agent:	Plan Administrator Use Only:	
Zachary Zimmerman	PBC 6CA.110.07.09	Code:

EXHIBIT 13

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
866-400-7102

CERTIFICATE OF INSURANCE
PROVIDING SHORT TERM MAJOR MEDICAL INSURANCE

Group Policy No. STM600-1 ("the policy"), has been issued to Consumer Benefits of America which we will refer to as "the Policyholder". We will refer to HCC Life Insurance Company as "the Company", "we", "us", "our".

The policy was delivered in Missouri and will be governed by the laws thereof.

This Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers can authorize a change of the policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

Signed for HCC Life Insurance Company:

President: 

Corporate Secretary: 

THIS CERTIFICATE IS EVIDENCE OF A CONTRACT
BETWEEN THE POLICYHOLDER AND THE COMPANY
READ IT CAREFULLY

For service or complaints about this policy, please address any inquiries to the address shown above or call 866-400-7102.

TABLE OF CONTENTS

NOTE: NO CONTINUOUS COVERAGE. This Certificate of insurance provides coverage for a short term duration only. It is not renewable.

PART I – GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes injury to one or more Covered Persons.

"Complications of Pregnancy" means:

1. Conditions requiring Inpatient treatment (when pregnancy is not terminated);
2. Whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as hyperemesis gravidarum, preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Doctor prescribed rest during the period of pregnancy, morning Sickness, and other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
3. Non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

"Congenital Condition" means a disease or other anomaly existing at or before birth, whether acquired during development or by heredity.

"Coverage Period" means the length of time which the Insured selected in the Insured's application and approved by us, not to exceed a 6 [Six] month period commencing on the Effective Date. The Insured's Coverage Period is shown in the Schedule of Benefits.

"Covered Person" means an Insured and his eligible dependents for whom coverage is in effect under the policy, as described in Part II – Eligibility and Effective Date of Insurance Provisions and the Schedule of Benefits.

"Custodial or Convalescence Care" means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

"Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and must be satisfied each Coverage Period.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Eligible Dependent" means:

1. The Insured's lawful spouse; and
2. The Insured's unmarried children who are less than age 19. An unmarried child who is less than age 25 may also be included if the child is enrolled full-time in an accredited school or college.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures, and children for whom coverage has been court-ordered.

Dependent children (other than those for whom coverage has been court-ordered) must be primarily dependent on the Insured for principal support and maintenance.

Coverage for an unmarried dependent child who is:

A. incapable of self sustaining employment by reason of a physically or mentally disabling injury, illness or condition; who became so incapacitated prior to the attainment of the limiting age set forth above, and

B. chiefly dependent upon the Insured for support and maintenance, shall not terminate. Coverage shall continue as long as the certificate remains in force and the dependent is disabled. Proof of such incapacity and dependency must be furnished to Us within sixty (60) of receipt of notice by Us that such coverage will terminate. We will provide such notice at least 90 days prior to the date the Dependent child attains the limiting age. Continued proof may be requested, but not more frequently than once a year.

“Durable Medical Equipment” means medical equipment that can withstand repeated use, is prescribed by a Physician, and is appropriate for use in the home. Covered DME is limited to a standard basic Hospital bed and/or a standard basic wheel chair.

“Effective Date” means the date the Insured’s (and Eligible Dependents’ if applicable) coverage under the policy is effective.

“Experimental Treatment” means in Our discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.
3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise experimental in nature.

“Extended Care Facility” means an institution, other than a Hospital, operated and licensed pursuant to law, that provides:

1. Permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their illnesses or injuries;
2. Full-time supervision of a Doctor;
3. Twenty-four (24) hour a day nursing service of one or more Nurses; and
4. Is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addiction or alcoholism.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:

1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

"Home Health Care Plan" means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the plan, an attending Doctor must certify that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility.

"Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"Injury" means accidental bodily Injury of a Covered Person:

1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury.

"Inpatient" means a person who incurs medical expenses for at least one day's room and board from a Hospital.

"Insured" means a person who meets the eligibility requirements for an Insured as stated in the Master Application and the policy, and whose coverage under the policy has become effective and has not terminated.

"Medically Necessary" means the care, service or supply is:

1. Prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
2. Appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care, service or supply, is given.

“Mental and Nervous Disorder” means a “biologically-based” mental disorder, including Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, Paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Delirium and dementia, Affective disorders, and any other "biologically-based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the "DSM").

“Outpatient” means a person who incurs medical expenses at Doctor’s offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

“Regular and Customary Activities” means an Insured Person can carry on a substantial part of the standard and commonly practiced activities of a person in good health of the same sex and age. Activities performed while confined in a Hospital or other medical institution may not be used to meet this requirement.

“Routine Physical Exam” means examination of the physical body by a Doctor for preventive or informative purposes only, and not for the diagnosis or treatment of any condition.

“Sickness” means Sickness or disease of a Covered Person that:

1. Is treated by a Doctor while the person is covered under the policy; and
2. Results directly and independently of all other causes in loss covered by the policy.

“Substance Abuse” means the overindulgence in and dependence on a psychoactive leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others.

“Surgery or Surgical Procedure” means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Doctor while the patient is under general or local anesthesia.

“Total Disability” (or “Totally Disabled”) means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, “Totally Disabled” means the inability to perform a majority of the normal activities of a person of like age in good health.

“Urgent Care Center” means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

“Usual and Customary” charges means the following:

1. A usual fee is defined as the charge made for a given service by a Doctor to the majority of his or her patients; and
2. A customary fee is one that is charged by the majority of Doctors within a community for the same services. All benefits are limited to Usual and Customary charges.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Coverage will be effective for an Insured and his Eligible Dependent(s) as of the approved Effective Date, provided:

1. The Insured meets the eligibility requirements set forth in the Master Application and the Policy;
2. The Insured's Application is approved by Us;
3. The first premium payment is received on or before the date the Insured's Application is approved by Us;
4. The Insured is not confined at home or in a Hospital or medical institution as of the Effective date; and
5. The Insured is engaging in his Regular and Customary Activities as of the Effective date.

If the Insured is not engaged in his Regular and Customary Activities or is confined in a Hospital or medical institution on the Effective Date, coverage will begin the first day he can engage in his Regular and Customary Activities and is not confined in a Hospital or medical institution.

The Company will require satisfactory evidence of insurability for each Insured and Eligible Dependent.

Newborn Child Coverage: A child of the Insured born while the policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth together with additional premium must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for Injury and Sickness provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the Insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by the policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.

PART III - TERMINATION OF INSURANCE

Coverage of a Covered Person under the Policy shall automatically terminate on the earliest of the following dates:

1. The date the Coverage Period expires;
2. The first day of the month coinciding with or following the date other hospital, major medical, group health or other medical insurance coverage becomes effective for a Covered Person;
3. The end of the last period for which the last required premium payment was made for the Insured's or Covered Person's insurance;
4. The date a Covered Person receives the Coverage Period Maximum Benefit Amount;
5. The date the Covered Person enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The premium due date that coincides with or next follows the date on which the Insured is no longer eligible;
7. For a Dependent spouse, the first day of the month following the date of divorce or legal separation from the Insured; or
8. The date We specify that the Covered Person's insurance is terminated because of:
   A. Failure to provide any signed release, consent, assignment or other documents requested by Us;
   B. Failure to fully cooperate with Us in the administration of the Policy;
   C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under the Policy; or
   D. Misuse of the Covered Person's identification card.

At the death of an Insured, all rights and privileges as a Covered Person under the Policy will transfer to the surviving Dependent spouse. The Dependent spouse will then be considered an Insured instead of a Dependent. In the event the Dependent spouse remarries, coverage under the Policy for the Dependent Spouse and Dependent child(ren), if any, will end on the first day of the month following the date of that marriage. If no surviving Dependent spouse, or at the death of a surviving Dependent spouse, all rights and privileges as a Covered Person under the Policy will transfer to each Dependent child, if any, and he will be considered the Insured instead of a Dependent.

If the Insured selected the Pay In Advance option in the Insured's Application and We received all required premium for the Coverage Period, premium will be reimbursed to the Insured for the period of time, if any, between the date coverage terminates in accordance with the above provisions and the end of that Coverage Period.

Extension of Benefits

If a covered Bodily Injury or Sickness commences while the Policy is in force as to a Covered Person, benefits otherwise payable under the Policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. The date the Total Disability ends;
2. The date when treatment for the Total Disability is no longer required;
3. The date following a time period equal to the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;
4. The date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. The date the Coverage Period Maximum Benefit amount has been reached

PART IV - PREMIUMS

1. Unless the Pay In Advance option has been chosen, premium due dates for an Insured will be on the Effective Date and then the same date of each following calendar month. If a month has fewer days than the scheduled premium due date, premium will be due on the last day of the month. All insurance shall be charged from and to the premium due date.
2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves collecting earned premiums, or returning unearned premium shall be limited to the six (6) months immediately preceding the date of determination that the adjustment in premium should be made.
3. Premiums shall be payable in advance to Us at Our Home Office.
4. If the Insured has not given written notice to Us that insurance is to be terminated prior to the premium due date, a grace period of thirty-one (31) days beginning from the premium due date will be allowed for any premium after the first premium. If the Insured fails to pay premium before the grace period expires all coverage shall lapse as of the premium due date.
5. The Policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to the Policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

PART V – DESCRIPTION OF MEDICAL EXPENSES

Subject to the Deductible, Coinsurance and other limits set forth in PART X – SCHEDULE OF BENEFITS, the Company will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   - A. Daily room and board and nursing services not to exceed the average semi-private room rate;
   - B. Daily room and board and nursing services in Intensive Care Unit;
   - C. Use of operating, treatment or recovery room;
   - D. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients;
   - E. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   - F. Emergency treatment of a Sickness; however, an additional $250 Deductible will apply to emergency room charges unless the Covered Person is directly admitted to the Hospital as an Inpatient for further treatment of that Sickness.
2. For Surgery at an Outpatient surgical facility, including services and supplies.
3. For charges made by a Doctor for professional services.
4. For charges made by a Doctor for Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual and Customary charge of the primary surgeon. (Standby availability will not be deemed to be a covered charge.).
5. For dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except Durable Medical Equipment as herein defined.
6. For diagnostic testing using radiology, ultrasonographic or laboratory services
(psychometric, intelligence, behavioral and educational testing are not included).
7. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs,
but not the replacement or repair thereof.
8. For reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease:
   - A. to improve function; or
   - B. to create a normal appearance, to the extent possible.
9. Reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also be extended to include surgery on a non-diseased breast to establish symmetry with the diseased breast. As used in this benefit:
   - A. “Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer.
   - B. “Reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty, and mastopexy.

   Coverage for prosthetic devices and reconstructive surgery means any initial or subsequent surgeries, prosthetic devices and any Medically Necessary follow up care.
10. For radiation therapy or treatment and chemotherapy.
11. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
12. For oxygen and other gasses and their administration by or under the supervision of a doctor.

13. For anesthetics and their administration by a Doctor, subject to a maximum of 20% of the benefit payable for the primary surgeon.
14. Extended Care Facility charges for room and board accommodations; if:
    A. The Insured is an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;
    B. The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
    C. That confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.
15. Treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Eligible Expenses for Home Health Care are the Maximum Allowable Charges made for the following:
    A. Part-time skilled nursing care;
    B. Physical therapy;
    C. Speech therapy;
    D. Medical supplies, drugs and medicines prescribed by a Doctor;
    E. Laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under the Policy had the Insured Person remained Hospitalized;
    F. Occupational therapy; and
    G. Respiratory therapy. However, benefits will not be paid for charges made by a Home Health Care Agency for:
    A. Any charges excluded under the Exclusions of the certificate;
    B. Full-time nursing care at home;
    C. Meals delivered to the home;
    D. Homemaker services;
    E. Any services of an individual who ordinarily resides in the Insured's home or is a member of the Insured's immediate family; or
    F. Any transportation services.

    Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the certificate.
16. Local Ambulance transport necessarily incurred in connection with Injury, and Local Ambulance transport necessarily incurred in connection with Sickness resulting in Inpatient hospitalization.
17. Dental treatment and dental surgery necessary to restore or replace natural teeth lost or damaged as a result of an Injury covered under this certificate.
18. Medically Necessary rental of Durable Medical Equipment (limited to a standard basic hospital bed and/or a standard basic wheelchair) up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.
19. Physical Therapy if prescribed by a Doctor who is not affiliated with the Physical Therapy practice, necessarily incurred to continue recovery from a covered Injury or Sickness.

Pre-Certification Requirements

1. All hospitalizations, other Inpatient care, and Surgeries or Surgical Procedures must be Pre-certified.
2. To comply with the Pre-certification requirements, the Covered Person must:

A. Contact the Company at 1-866-400-7102 as soon as possible before the expense is to be incurred; and
B. Comply with the instructions of the Company and submit any information or documents they require; and
C. Notify all Doctors, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

3. If the Covered Person complies with the Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions described in this certificate. If the Covered Person does not comply with the Pre-certification requirements or if the expenses are not Pre-certified:
   A. Eligible Medical Expenses will be reduced by 50%; and
   B. The Deductible will be subtracted from the remaining amount; and
   C. The Coinsurance will be applied.
4. Emergency Pre-certification: In the event of an emergency Hospital admission, Pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.
5. Pre-certification Does Not Guarantee Benefits – The fact that expenses are Pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.
6. Concurrent Review – For Inpatient stays of any kind, the Company will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if a Covered Person receives prior approval.

Pre-Certification Requirements for reconstructive surgery in connection with a mastectomy shall not be required in determining length of stay in a hospital following such surgery or procedure. Only a Doctor competent to evaluate the specific clinical issues involved in the care requested, can deny a request to authorize care for reconstructive surgery.

State Mandated Benefits.
The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Period Maximum Benefit amounts shown on the Schedule of Benefits.

1. **Dental Anesthesia** – Coverage shall be provided for general anesthesia for dental care for a Dependent child if an underlying medical condition requires such anesthesia to be provided in a hospital or surgery center setting. Coverage shall only include payment for:
   A. anesthesia; and
   B. hospital or surgery center setting charges.

   The Dependent child must meet the following conditions:
   A. be under the age of seven (7); or
   B. be developmentally disabled, regardless of age; and
   C. it is determined that such child's health is compromised and general anesthesia is Medically Necessary.

2. **Child Preventive Care** - Coverage shall be provided for comprehensive child preventive care consistent with the following for children 16 years of age or younger:
   A. The recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics of September 1987;

B. The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the:
   (a) American Academy of Pediatrics;
   (b) Advisory Committee on Immunization Practices; and
   (c) American Academy of Family Physicians;
   unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this benefit provision. and

C. Include benefits for:
   (a) periodic health evaluations;
   (b) immunizations; and
   (c) laboratory services in connection with periodic health evaluations.

3. **Mammography Screening** - Coverage shall be provided for the screening and diagnosis of breast cancer based on the following:
   A. A baseline mammogram for a woman who is thirty-five (35) to forty (40) years of age;
   B. A mammogram for a woman who is forty (40) to forty-nine (49) years of age, every two years, or more frequently, based on the recommendation of the woman's Doctor;

   C. A mammogram each year for a woman who is at least fifty years (50) of age;

4. **Laryngectomy** - Coverage shall be provided for prosthetic devices to restore speech after a laryngectomy.
   As used here:
   Laryngectomy means the Medically Necessary removal of the larynx.

   Prosthetic devices means initial and replacement prosthetic devices, including installation accessories prescribed by a Doctor. It does not include an electronic voice producing machine.

5. **Prostate Screenings** - Coverage shall be provided for the screening and diagnosis of prostate cancer. Coverage shall include, but not be limited to:
   A. prostate specific antigen testing; and
   B. digital rectal examinations.

   Coverage does not include:
   A. radical prostatectomy;
   B. external beam radiation therapy;
   C. radiation seed implants; or
   D. combined hormonal therapy.

6. **Cervical Cancer Screenings** - Coverage shall be provided for an annual cervical cancer screening test including a Pap test or any cervical cancer screening test approved by the FDA and recommended by a Doctor.

7. **Cancer Screening Tests** - Coverage shall be provided for generally medically accepted cancer screening tests.

8. **Phenylketonuria (PKU) Treatment** - Coverage shall be provided for the testing and treatment of phenylketonuria (PKU). Such coverage will include formulas and special food products that are:
   A. part of a diet prescribed by a Doctor;
   B. managed by a health care professional in consultation with a Doctor who specializes in the treatment of metabolic disease.

   Such diet must be Medically Necessary to avoid the development of a serious physical or mental disability; or to promote normal development or function as a consequence of PKU. Coverage is only required to the extent it exceeds the cost of a normal diet.

   As used here:
   "Formula" means an enteral product for use at home that is prescribed or ordered by a Doctor or other authorized health care provider as Medically Necessary for the treatment of PKU.

   "Special food products" means a food product that is both:
   A. prescribed by a Doctor for the treatment of PKU and consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
   B. used in place of normal food products, such as grocery store foods , used by the general population.

9. **Osteoporosis** - Coverage shall be provided for the diagnosis, treatment and appropriate management of osteoporosis. Coverage will include, but not be limited to, FDA approved technologies such as bone mass measurement, as deemed medically appropriate.

10. **Severe Mental Illness/Serious Emotional Disturbances of a Child** - Coverage for Medically Necessary treatment shall be provided for:
   A. diagnosis and treatment of severe mental illness for a Covered Person of any age; and
   B. emotional disturbances of a child who:
      (a) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to such child's age according to expected development norms; and
      (b) meets one or more of the following:
         (i) displays psychotic features, risk of suicide, or risk of violence due to a mental disorder; or
         (ii) meets special education eligibility requirements pursuant to California state law; or
         (iii) has substantial impairment, as a result of the mental disorder, in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and either of the following occur: the child is at risk of removal from his/her home or has already been removed from the home; or the

mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

Benefits shall include charges incurred for:

1. Outpatient services;
2. Inpatient hospital services, including inpatient prescription drugs and
3. Partial hospital services.

As used here:
"Severe mental illness" shall include:

1. Schizophrenia or schizoaffective disorder; or
2. Bipolar disorder (manic-depressive illness); or
3. Major depressive disorder; or
4. Panic disorder; or
5. Obsessive-compulsive disorder; or
6. Pervasive developmental disorder or autism; or
7. Anorexia nervosa or bulimia nervosa.

11. **Diabetes** - Coverage shall be provided for Medically Necessary supplies, equipment and management and treatment of insulin using diabetes, non-insulin using diabetes and gestational diabetes. Coverage shall include:

A. Blood glucose monitors, including glucose monitors for the visually impaired;
B. Blood glucose test strips, ketone urine testing strips;
C. Insulin pumps and related necessary supplies;
D. Lancets and lancet puncture devices;
E. pen delivery systems for the administration of insulin;
F. Podiatric devices to prevent or treat diabetes related complications;
G. Insulin syringes;
H. Visual aids (but not eyewear) to assist the visually impaired with proper dosing of insulin.

Coverage shall also include outpatient self-management training, education and medical nutrition therapy services necessary to enable the Covered Person to properly use the equipment and supplies listed above. Such services must be provided by an appropriately licensed or registered health care professional as prescribed by a health care professional legally authorized to prescribe the services.

12. **AIDS Vaccine** – Coverage shall be provided for a vaccine for Acquired Immune Deficiency Syndrome (AIDS) that is approved by the FDA and recommended by the U.S. Public Health Service.

13. **Cancer Clinical Trials** - Coverage shall be provided for routine patient costs for a Covered Person diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer. The Covered Person's Doctor must recommend participation in the clinical trial and determine that it will have a meaningful potential benefit. Treatment must be provided in a clinical trial that:

A. involves a drug that is exempt under federal regulations from a new drug application; or
B. is approved by one of the following:
   (a) one of the National Institutes of Health (NIH);

(b) the FDA, in the form of an investigational new drug application;
(c) the U.S. Department of Defense; or
(d) the U.S. Veterans' Administration.

"Routine patient costs" means costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

A. Health care services typically provided absent a clinical trial.
B. Health care services required solely for the provision of the investigational drug, item, device, or service.
C. Health care services required for the clinically appropriate monitoring of the investigational item or service.
D. Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
E. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

It does not include:

A. drugs or devices not approved by the FDA and that are associated with the clinical trial;
B. services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses;
C. any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
D. health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded under this certificate; or
E. health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

PART VI – EXCLUSIONS

Charges for the following treatments and/or services and/or supplies and/or conditions are excluded from coverage:

1. Pre-existing Conditions – Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the six (6) month period immediately preceding such person's Effective Date are excluded for the first six (6) months of coverage hereunder. A Covered Person who was covered under creditable coverage within 63 days of enrolling under this certificate shall be given credit for the period of time under such coverage toward the satisfaction of this exclusion. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this certificate in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE. Creditable Coverage means any of the following:
   - A. A group health plan; or
   - B. Health insurance coverage (care under any hospital or medical service policy or certificate; hospital or medical service plan contract; or Health Maintenance Organization (HMO); or
   - C. Individual coverage; or
   - D. Medicare; or
   - E. Medicaid; or
   - F. CHAMPUS; or
   - G. A medical care program of the Indian Health Service or of a tribal organization; or
   - H. A State health benefits risk pool; or
   - I. A health plan offered under the Federal Employees Health Benefits Program (FEHBP); or
   - J. A public health plan; or
   - K. A health benefit plan under the Peace Corps Act.

   Creditable coverage does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, workers' compensation insurance or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

   Any coverage under which an insured was covered prior to a break in coverage of 63 consecutive days or more, not counting any waiting period or affiliation period required by any Creditable Coverage, will not be considered Creditable Coverage.
2. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
3. Routine pre-natal care, Pregnancy, childbirth, and postnatal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
4. Alcoholism.
5. Substance abuse.
6. Charges which are not incurred by a Covered Person during his/her Coverage Period.
7. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor.
8. Treatment, services or supplies which are not Medically Necessary as defined.
9. Treatment, services or supplies provided at no cost to the Covered Person.

10. Charges which exceed Usual and Customary charge as defined.
11. Telephone consultations or failure to keep a scheduled appointment.
12. Consultations and/or treatment provided over the Internet.
13. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.
14. All charges Incurred while confined primarily to receive Custodial or Convalescence Care.
15. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
17. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this certificate.
18. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
19. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
20. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
21. Dental treatment, except for dental treatment that is expressly covered under this certificate.
22. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
23. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
24. Treatment for cataracts.
25. Treatment of the temporomandibular joint, except for medically necessary surgical procedures for covered conditions directly affecting the upper or lower jawbone or associated bone joints.
26. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultra light gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting.
27. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports.
28. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.
29. Willfully self-inflicted Injury or Sickness.
30. Immunizations and Routine Physical Exams, except as expressly covered under this certificate or under a Rider attached to this certificate.
31. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.
32. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.

33. Any services performed or supplies provided by a member of the Insured's Immediate Family.
34. Orthoptics and visual eye training.
35. Services or supplies which are not included as Eligible Expenses as described herein.
36. Care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
37. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
38. Treatment of sleep disorders.
39. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs.
40. Any services or supplies in connection with cigarette smoking cessation.
41. Exercise programs, whether or not prescribed or recommended by a Doctor.
42. Treatment required as a result of complications or consequences of a treatment or condition not covered under this certificate.
43. Charges for travel or accommodations, except as expressly provided for local ambulance.
44. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
45. Organ or Tissue Transplants or related services.
46. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.
47. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
48. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this certificate.
49. Spinal manipulation or adjustment.
50. Sclerotherapy for veins of the extremities.
51. Expenses during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion):
    A. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
    B. Tonsillectomy;
    C. Adenoidectomy;
    D. Repair of deviated nasal septum or any type of surgery involving the sinus;
    E. Myringotomy;
    F. Tympanotomy;
    G. Herniorrhaphy; or
    H. Cholecystectomy.
52. Chronic fatigue or pain disorders.
53. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
54. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
55. Kidney or end stage renal disease.
56. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.

57. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
58. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

PART VII – COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any coverage year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance or accidental death and dismemberment benefits.

The term "plan" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "plan" also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid.

Definitions. "Plan" – means any of the following which provides benefits or services for medical expenses:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

Each contract or other arrangement for coverage under the above paragraphs is a separate plan. Also, if an arrangement has two parts and COB rules apply to one of the two, each of the parts is construed to mean a separate Plan.

The term "plan" does not include:

1. Individual or family insurance or subscriber contracts;
2 Individual or family coverage through Health Maintenance Organizations (HMOs);
3. Individual or family coverage under other prepayment, group practice and individual practice plans;
4. School accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a to-and-from school basis);
5. Group or group-type hospital indemnity benefits of $100 per day or less;
6. Medicare Supplement policies;
7. A state plan under Medicaid.

"Primary Plan (Primary)" – means the Plan which determines its benefits before those of the other Plan. When there are more than two (2) Plans, This Plan may be Primary as to one and Secondary as to another.

"Secondary Plan (Secondary)" – means the Plan which determines its benefits after those of the other Plan. When there are more than 2 Plans, This Plan may be Secondary as to one and Primary as to another.

"This Plan" – means the benefits provided under this group policy.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If the Primary Plan's payment is less than the charge for the allowable expense, then the Secondary Plan will apply its benefit payment to the balance.
The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the Primary Plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
   A. First, benefits of a plan covering persons as an employee, member, or subscriber.
   B. Second, benefits of a plan of an active worker covering persons as a dependent.
   C. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
   A. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
   B. If both parents have the same birthday the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
   C. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
   D. When the parents are separated or divorced and the parent with custody has not remarried the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   E. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
   F. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary

insured's dependent. This rule will not apply if the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   A. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   B. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6 When rules 2 through 5 do not establish an order of benefit determination the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by us we have the right to pay the other plan any amount we deem necessary to satisfy our obligation under these COB rules.

Right of Recovery. If the amount of our benefit payment is more than the amount needed to satisfy our obligation under these COB rules, we have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as we deem necessary; and
2. Any person claiming benefits under this plan must give us any information necessary to carry out this provision.

PART VIII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins or as soon as is reasonably possible. The notice must be given to the Company named on the Schedule of Benefits. Notice should include information that identifies the claimant and the policy.

Claim Forms: When the Company receives notice of claim, forms for filing proof of loss will be sent to the claimant. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

1. In writing;
2. Setting forth the nature and extent of the loss; and
3. Within the time stated in the Proof of Loss provision.

Proof of Loss: Written proof of loss must be given to the Company within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Company within one year after it is due unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss, but no later than 30 working days after We receive Proof of Loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to $1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

Third Party Liability: No benefits are payable for any Sickness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Company will advance the benefits of this policy to the Insured subject to the following**:**

1. The Insured agrees to advise Us, in writing, within 60 days of any Covered Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as We may require to facilitate enforcement of the claim. The Insured and Covered Person also agree to take no action that may prejudice Our rights or interests under this policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this policy and will result in the Insured being personally responsible for reimbursing Us.

2 We will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Covered Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this policy for the treatment of the Sickness, disease, Injury or condition for which the third party is liable.

Independent Medical Review: A Covered Person, or a representative acting on his or her behalf, has the right to request an independent medical review whenever healthcare services have been denied, modified or delayed by Us, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. A doctor, or other health care provider, may assist in seeking an independent medical review and may advocate on such Covered Person's behalf.

PART IX – GENERAL PROVISIONS

Time Limit on Certain Defenses: The validity of coverage issued under the Policy with respect to an Insured or his Eligible Dependents may not be contested after three years from each certificate's effective date, except for nonpayment of premiums.

Misstatement of Age: If the age of any Covered Person is incorrectly stated, we will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had we known the correct information.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Pronouns: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

PART X – SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name: MOHOMMED AZAD

Policy Effective Date: 12-09-2015

COVERAGE PERIOD: 6 Months

ELIGIBILE DEPENDENTS COVERED

COVERAGE AND BENEFIT AMOUNTS:

Deductible	2500 per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period. An additional Deductible of $250 per visit will be applied to charges for use of emergency room in the event of Sickness unless the Covered Person is directly admitted as an Inpatient for further treatment.
Coinsurance	During a Coverage Period, the Company will pay 80% of the next $5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.
Urgent Care Center	For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible
Hospital Room and Board	Average Semi-private room rate, including nursing services.
Local Ambulance	Injury: Usual and Customary charges to a Maximum of $250 per trip, when related to a covered Injury. Sickness: Usual and Customary charges to a maximum of $250 per trip, when covered Sickness results in hospitalization as Inpatient
Intensive Care Unit	Usual and Customary charges
Physical Therapy	$50 Maximum per visit per day
Home Health Care	Maximum 1 visit per day. Maximum of 40 visits during a Coverage Period
Extended Care Facility	Not to exceed a daily rate of $150 nor a maximum of 60 days

All Other Eligible Medical Expenses	Usual and Customary charges
Penalty for Failure to Pre-certify	50% of Eligible Medical Expenses
Overall Maximum Limit per Coverage Period	$2,000,000

EXHIBIT 14

GERARD G. PECHT *(Admitted Pro Hac Vice)*
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Los Angeles, California 90071
Telephone: (213) 892-9200
Facsimile: (213) 892-9494

Attorneys for Defendants
HCC LIFE INSURANCE COMPANY and HCC MEDICAL INSURANCE SERVICES, LLC *(erroneously sued as* TOKIO MARINE HCC – MEDICAL INSURANCE SERVICES GROUP)

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA – OAKLAND DIVISION

MOHAMMED AZAD and DANIELLE BUCKLEY, on behalf of themselves and all others similarly situated,

Plaintiffs,

v.

TOKIO MARINE HCC – MEDICAL INSURANCE SERVICES GROUP, HEALTH INSURANCE INNOVATIONS, INC., HCC LIFE INSURANCE COMPANY, and CONSUMER BENEFITS OF AMERICA,

Defendants.

Case No.: 4:17-cv-00618-PJH

MANUAL FILING NOTIFICATION

Date: May 24, 2017
Time: 9:00 a.m.
Ctrm : 3

Complaint Filed: February 7, 2017

Regarding: EXHIBIT 14 to the DECLARATION OF JON PADGETT

This filing is in paper or physical form only, and is being maintained in the case file in the Clerk's office. If you are a participant on this case, this filing will be served in hard-copy shortly. For information on retrieving this filing directly from the court, please see the court's main website at http://www.cand.uscourts.gov under Frequently Asked Questions (FAQ).

This filing was not efiled for the following reason(s):

___ Unable to Scan Documents

___ Physical Object (please describe): _____

_X_ Non-Graphic/Text Computer File (audio, video, etc.) on CD or other media

___ Item Under Seal in Criminal Case

___ Conformance with the Judicial Conference Privacy Policy (General Order 53)

___ Other (please describe): _____

Dated: April 14, 2017

GERARD G. PECHT
M. SCOTT INCERTO
JOSHUA D. LICHTMAN
MICHELLE L. MELLO
NORTON ROSE FULBRIGHT US LLP

By /s/ Joshua D. Lichtman
JOSHUA D. LICHTMAN
Attorneys for Defendants
HCC LIFE INSURANCE COMPANY and HCC MEDICAL INSURANCE SERVICES, LLC *(erroneously sued as* TOKIO MARINE HCC – MEDICAL INSURANCE SERVICES GROUP)

EXHIBIT 15

Steven Buckley

[redacted]

HCC Life Insurance Company

Short-Term Medical

STM ADMINISTERED BY HCC MEDICAL INSURANCE SERVICES

THANK YOU for your purchase of HCC Life Insurance Company's Short Term Medical coverage. Please review your coverage and application carefully. A few important reminders regarding your coverage are outlined below:

The insurance contains the lifetime maximum, co-insurance and deductible amounts that you selected at the time of application. The coverage contains exclusions for specific conditions and treatments as well as a pre-existing condition exclusion. The insurance does not pay for routine physicals or immunizations unless required by state law. In addition, hernia operations, gall bladder removal and other selected surgical procedures are not covered for the first 6 months the coverage is in force. HCC Life Insurance Company, in no event, will provide benefits in excess of those specified in the insurance contract. This insurance is not subject to guaranteed issuance or renewal.

Contact Us

service.hccmis.com

- Phone: 1-866-400-7102 / 317-221-8095
- Fax: 317-262-2140

Call Center hours are Monday-Friday from 7am-Midnight EST

Client Zone

https://zone.hccmis.com/clientzone/

- Update your information
- Reprint an ID card
- Change Mailing and Email addresses
- View product brochures

Pre-Existing Conditions:

- Charges resulting directly or indirectly from any pre-existing condition are excluded from this insurance.
- If you had an illness, and injury or condition at the time of purchase that you intended to have covered under this insurance, it will likely not be covered and you should consider using the free look provision.
- Please refer to the limits set forth in your Short Term Medical insurance provided at the time of purchase.

Important:

HCC Life's Short Term Medical Insurance Services is not subject to the Patient Protection and Affordable Care Act (PPACA). It does not contain many of the coverages required by PPACA. Depending on the time of year and individual circumstances, you can purchase PPACA compliant individual health insurance plans from your state's Health Insurance Marketplace.

Free Look Provision:

- Your insurance contract contains a free look period which allows you to cancel the coverage for any reason.
- All requests must be in writing and must be received by HCC Life within 10 days of the effective date of Coverage. All cancellation requests should be sent to orders@hccmis.com

Note – Indiana contracts have a 30 day free look period.

Cancellations (after Free Look period):

- Should you wish to cancel, please send a request to orders@hccmis.com *Note - the request must include your policy number and needs to come from the email address on file used to purchase the policy.
- If paying by monthly installments, a request needs to be submitted prior to your next installment date.
- Single up-front payments require proof of other insurance (with effective date) before a cancellation request can be processed.

Getting Medical Treatment:

- Show your ID card to the medical attendant.
- Pay the deductible or copay (if applicable).
- The medical office may submit bills directly to us.

After the visit, you will need to submit a Claimant's Statement.

Filing a Medical Claim:

- Submit original, itemized bills, and any payment receipts, and claim form service.hccmis.com
- A copy of a Claims Statement can be obtained by clicking: http://www.hccmis.com/downloads

Payment Receipt

For Certificate: [redacted]
Paid By: ***Steven Buckley***
Payment Type: ***VISA***
Number: ***xxxxxxxxxxxx7403***
Amount: ***$675.55***
Date Paid: ***3/31/2016***

Credit Card Payments Only
Expiration Date: ***1/19***
Trans. Code: ***1390213746***
Auth. Code: ***06054C***

HCC HCC Life Insurance Company

Covered Dependents:

Primary Insured:

Steven Buckley

Danielle Buckley
[redacted]

Certificate #: [redacted]
Plan #: STM600-1
Effective Date: 4/1/2016

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE

FOLD

• For general questions regarding Eligibility / Benefits / Claims, please call:

1-800-605-2282 *or*
1-317-262-2132

• Mail itemized bills including diagnosis to:

HCCMIS Claims Department
Box No. 2005
Farmington Hills, MI
48333-2005

• Claims may be submitted electronically using Payer ID: HCCMI

First Health. MMP Medical Management Programs, Inc.

HCC HCC Life Insurance Company

Covered Dependents:

Primary Insured:

Steven Buckley

Danielle Buckley
[redacted]

Certificate #: [redacted]
Plan #: STM600-1
Effective Date: 4/1/2016

POSSESSION OF THIS CARD DOES NOT GUARANTEE COVERAGE

FOLD

• For general questions regarding Eligibility / Benefits / Claims, please call:

1-800-605-2282 *or*
1-317-262-2132

• Mail itemized bills including diagnosis to:

HCCMIS Claims Department
Box No. 2005
Farmington Hills, MI
48333-2005

• Claims may be submitted electronically using Payer ID: HCCMI

First Health. MMP Medical Management Programs, Inc.

Consumer Benefits of America

Dear New Member,

As a consumer awareness initiative, Consumer Benefits of America has brought you this additional discount program on new or refill prescription medications available from over 59,000 participating retail pharmacies nationwide or by mail service. (No cost for this Rx program.)

RxSavingsPlus℠

Use your RxSavingsPlus drug discount card.

1) Take your prescription(s) into any of the over 59,000 participating pharmacies such as Walgreens, CVS and RiteAid.
2) Present your RxSavingsPlus card to the pharmacist along with your prescription(s).
3) Pay the pharmacy.

It's simply a great way to save money on prescription drugs. After working closely with pharmacies and drug manufacturers, we've negotiated lower prices for thousands of medications and share these savings with you.

To see how much you would save on your own prescription medications, call toll-free **1-877-673-3688**, visit **www.RXSavingsPlus.com** or ask at your local pharmacy. You may receive even greater savings – up to 50 percent – if your prescriptions are filled through our mail service.

Use one card for the entire household–even pets!

Visit us online today to see how much you can save.
www.RXSavingsPlus.com

This program is not insurance. Savings are only available at participating pharmacies.

RxSavingsPlus℠
Pharmacy Discount Card
This program is not insurance.

ID: [redacted]
NAME: Steven Buckley
RXBIN: 004336
RXPCN: ADV
RXGRP: RXCBA02
ISSUER: (80840)

FOLD

CVS CAREMARK | CAREMARK®

Members: Call toll-free **1-877-673-3688** or go to **www.RxSavingsPlus.com** to locate a pharmacy provider.

Pharmacists: The RxPCN, RxGRP and full member ID must be submitted online to process claims for this program. Always use an 01 person code to process claims for this program. For information, contact us at **1-800-364-6331**.

Choice Member Benefit Guide

Consumer Benefits of America
PO Box 281248
Denver, CO 80228

Dear New Member,

Welcome to Consumer Benefits of America (CBA), an Association established 1982 to serve YOU, the consumer.

This Membership Guide and ID Card contain important phone and I.D. numbers necessary for "easy access" when utilizing the savings and services within this guide available to you and your family.

Since its inception, CBA has always been extremely conscientious in its efforts to provide quality savings and service for its members. Our expectations are that you will be extremely pleased.

RxSavingsPlus℠

As a consumer awareness initiative, Consumer Benefits of America has brought you this additional discount program on new or refill prescription medications available from over 59,000 participating retail pharmacies nationwide or by mail service. (No cost for this Rx program.)

Use your RxSavingsPlus drug discount card.

1) Take your prescription(s) into any of the over 59,000 participating pharmacies such as Walgreens, CVS and RiteAid.
2) Present your RxSavingsPlus card to the pharmacist along with your prescription(s).
3) Pay the pharmacy.

It's simply a great way to save money on prescription drugs. After working closely with pharmacies and drug manufacturers, we've negotiated lower prices for thousands of medications and share these savings with you.

To see how much you would save on your own prescription medications, call toll-free **1-877-673-3688**, visit **www.RXSavingsPlus.com** or ask at your local pharmacy. You may receive even greater savings – up to 50 percent – if your prescriptions are filled through our mail service.

Use one card for the entire household–even pets!

Save an average of 20 percent. Visit us online today to see how much you can save.
www.RXSavingsPlus.com

This is not insurance. Discounts are only available at participating pharmacies. Savings may vary by drug and by pharmacy. Savings are based on actual 2007 drug purchases for all drug discount card programs administered by Caremark. The program administrator may obtain fees or rebates from manufactures and/or pharmacies based on your prescription drug purchases. These fees or rebates may be retained by the program administrator or shared with you and/or your pharmacy. By using this card, you agree that you are responsible for paying the entire prescription cost of the medication after the application of any applicable discount. Prescription claims through this program will not be eligible for reimbursement through Medicaid, Medicare or any other government program.

RxSavingsPlus℠ Frequently Asked Questions (FAQ's)

General Questions

Does everyone in my family need an individual card?
No. Everyone in the family may use the same card if desired.

Can I use this card to get discounts on my pet's medications?
Yes, if your pet has been prescribed a medication, you may receive a discount on the medication by taking the prescription to a participating retail pharmacy.

I just received my card. Can I use it right away?
Yes, just use your card to start saving immediately. Present your prescription discount card at a participating retail pharmacy when you fill or refill your prescriptions.

Can I use my card to get discounts on over-the-counter products and non-prescription medications?
Not usually. However, discounts are available for many diabetic supplies.

How is this prescription discount program different from traditional prescription insurance?
This program is not insurance; it is a prescription drug discount program. The card provides immediate discounts at the pharmacy. Upon presenting your card to the pharmacist, you will pay the lower of a discounted price or the

pharmacy's regular retail price. There are no claim forms to fill out and no limit to the number of times you can use the card. **These discounts are available only at participating pharmacies.**

Can I use my prescription discount card with my current insurance benefit to reduce my costs?
Your card cannot be used in conjunction with other insurance. However, you are able to use your card to purchase prescriptions that are not covered by these plans.

About the Caremark Mail Service Program

What is mail service?
As a participant of the RxSavingsPlus program you are automatically eligible for the **Caremark Mail Service** program. With this program you can purchase up to a 90-day supply of select, long term, maintenance medications from the mail service pharmacy for a fixed price. It's easy to get started with mail service—just send in a mail service order form along with your original prescription, to Caremark. For a list of medications available, and to receive an order form, please visit www.RXSavingsPlus.com or call toll-free 1-877-673-3688.

About Specialty Pharmacy

What is specialty pharmacy and what kinds of services do they offer?
Specialty pharmacy offers delivery of injectable and select oral specialty medication and supplies to the location of your choice. Services include delivery notification and refill reminder calls to help you stay on your treatment plan. You'll also receive expert care services including counseling, follow up care calls, informative disease-related materials, and access to health experts 24 hours a day, seven days a week.

What drugs are offered through specialty pharmacy?
Medications for a variety of chronic conditions including multiple sclerosis, rheumatoid arthritis, cystic fibrosis, hemophilia, infertility, immunologic disorders, Crohn's disease, Gaucher disease, pulmonary hypertension, Fabry disease, MPS 1, blood dyscrasia, growth hormone deficiency, respiratory syncytial virus, hepatitis C, and more are available through the specialty pharmacy.

LEGALCARE America Legal Assistance Program

LEGALCARE America is an innovative program designed to provide CBA members with easy, confidential access to the legal assistance you require in your business, professional and personal affairs.

The American Bar Association estimates that 150 million Americans have virtually no access to even the most basic of legal assistance. The reasons for this are three-fold:
- They do not know how to find the right attorney;
- They are concerned that they cannot afford the cost; and
- They are afraid to speak with an attorney.

Through your LEGALCARE benefit, you are provided with the ability to solve each of these concerns.

From time to time, we all face legal concerns and challenges that could be better handled if an attorney were consulted. Have you ever:
- Thought about writing or revising your will?
- Purchased a home or automobile?
- Purchased a defective product and been ignored by the merchant or manufacturer?
- Paid a bill that you knew was unfair?
- Received an unjust traffic ticket?
- Had a problem with child support, separation, visitation, guardianship, or divorce?
- Signed a legally binding document and been sorry later?

With LEGALCARE, the assistance is just a phone call away. Over 88% of callers to LEGALCARE have their problem resolved by phone.

LEGALCARE is available on a nationwide basis from 8 a.m. to 6 p.m. your local time, Monday through Friday. LEGALCARE's services include:

- **Helpline.** A free legal "helpline" which allows you to call and speak with an attorney to obtain legal advice, information and answers to questions or problems relating to your business, professional or personal matters. There is no limit to the number of calls or the length of time you may spend on the telephone with the "helpline" attorney.

- **Referrals.** Anytime you need legal representation, you will be provided with the name of one or more attorneys who participate with LEGALCARE as a "referral" law firm. All referrals will be to attorneys who specialize in your area of need and who are near your home or office. "Referral" attorneys will provide a 30-minute FREE initial consultation and discount their standard billing rate 25% for any legal issue for which you choose to hire them.

Contacting LEGALCARE is as easy as picking up the telephone. Anytime you have a question, or need a referral, all you need to do is call LEGALCARE's toll-free number 877-377-2273. You will speak with an operator who will ask for certain information. An attorney will return your call within 24 hours.

This LEGALCARE America benefit has an exclusion relating to Consumer Benefits of American and affiliates.

Discount Flowers and Gifts

Save 15% With FTD.COM®!

FTD.COM is the premiere name in flowers and specialty gifts. We utilize only the finest FTD® florists to deliver your floral arrangements, and we offer a customer satisfaction guarantee. Because of FTD.COM's vast network of florists, we offer same day delivery throughout Canada and the United States and offer floral delivery to more than 150 countries worldwide. And with FTD.COM's free online personal account services, gift giving has never been easier! Order online at www.ftd.com/buynet or call 1-800-SEND-FTD and ask for promotion code 2591 and save 15%!

With over 1000 floral and non-floral items to choose from you are bound to find something to make someone's day. Choose from brand name specialty gifts from Ghirardelli, Mrs. Field's, Build-A-Bear, Gevalia coffee and more

So make someone's day special with FTD.COM!

Order online at www.ftd.com/buynet or call 1-800-736-3383
and ask for promotion code 2591 and save 15%!

Budget Truck Rental

Rent a Truck From a Company That's With You at Every Turn
When it's time to move you can save money by doing it yourself. Now Budget can save you even more money.

We'll Be Along For The Ride
You'll have the strength of the world's largest transportation resources company backing you with the rental industry's most comprehensive network of support services & benefits like a toll free customer service number, 24-hour emergency road service, and literally thousands of Budget dealers nationwide.

For Rates, Locations & Reservations:
1. Call our national reservation center at (800) 566-8422.
2. Simply use our Association Account # 56000058282, to receive a 15% discount off time and mileage rates on any local or one-way rental.
3. Have these details ready: pick up location (zip codes are helpful if the exact location is unknown), truck size and number of days needed.

North American Van Lines

Special discounts are now available to Buying Network members through North American Van Lines

As a member your receive the following basic discounts on interstate moves:
1. 50% minimum bottom-line discount (excluding third party, valuation and storage).
2. 45% discount on storage related needs.
3. No "Peak Season" rates (normally 10% higher June through August).
4. Up to $50,000 coverage on your household goods at no additional cost.

One call to North American Van Lines will assist you in your relocation before, during and after your move. For more information call: 1-800-524-5533, and make sure to identify yourself as a Buying Network member.

Auto Rental Discounts

CBA members receive special discounts through National and Alamo by simply calling the toll-free numbers listed below and providing the Customer Service Representative with the corresponding rate code.

Members receive discounts on selected auto rentals through most major companies: Alamo, Budget, Dollar, National and Thrifty auto rental agencies. (Current discounts are subject to change without notice). These discounts apply to rentals at all participating locations in the United States, Canada, and worldwide. Members are encouraged to check with their rental agent for details.

All major credit cards are accepted for payment of rentals. Should a cardholder elect to pay cash, a cash deposit is usually required at the time of rental.

Access to the Auto Rental Discount Program:

Alamo
1-800-354-2322, request rate code (BY) 32173

Budget
1-800-527-0700, T0 85558

Dollar
1-800-800-4000, CB2102

National
1-800-227-7368, recap 5120110

Thrifty
1-800-367-2277, 001-002-8034

Quarterly CBA Newsletter

CBA members receive a subscription to this CBA online membership publication. We will keep in touch by bringing you information you can use to manage your finances, improve your health or take a vacation. CBA will notify members of any benefit changes in this publication. You can download this professionally prepared quarterly periodical from www.cbanewsletter.com. Enter the password CBA. If you do not have web access, please call 800-707-8339 and request that your copies of the newsletters be mailed to you.

CBA National Headquarters
PO 67, Jefferson City, MO 65102

CBA Administrative Office
PO Box 281248 · Denver, CO 80228
303-463-7540 · 800-707-8339 · Fax 303-940-1746

Consumer Benefits of America

Questions concerning Association Benefits should be directed to:
CBA Administrative Office, PO Box 281248, Denver, CO 80228
303-463-7540/800-707-8339 Fax 303-940-1746

LegalCare America - 877-377-2273, ID CBA

Discount Flowers and Gifts - 1-800-SEND-FTD (1-800-736-3383), ask for promotional code 2591 and save 15%, www.ftd.com/buynet

Budget Truck Rental - 800-566-8422, Code 56000058282

North American Van Lines - 800-524-5533, ID "The Buying Network"

Auto Rental Discounts

Budget - 800-527-0700, TO 85558
Dollar - 800-800-4000, CB2101
National - 800-227-7368, recap 5120110
Thrifty - 800-367-2277, 001-002-8034
Alamo - 800-354-2322, code (BY)32173

HCC LIFE INSURANCE COMPANY
225 TownPark Drive, Suite 350
Kennesaw, Georgia 30144
866-400-7102

CERTIFICATE OF INSURANCE
PROVIDING SHORT TERM MAJOR MEDICAL INSURANCE

Group Policy No. STM600-1 ("the policy"), has been issued to Consumer Benefits of America which we will refer to as "the Policyholder". We will refer to HCC Life Insurance Company as "the Company", "we", "us", "our".

The policy was delivered in Missouri and will be governed by the laws thereof.

This Certificate of Insurance is evidence of the Insured's insurance under the policy and of its benefits. Everything contained in this Certificate of Insurance is subject to the provisions, definitions, and exceptions in the policy. The policy is on file with the Policyholder and may be examined at any reasonable time. Only one of our executive officers can authorize a change of the policy.

This Certificate replaces all Certificates and Certificate Riders, if any, previously issued to the Insured under the policy.

Signed for HCC Life Insurance Company:

President:

Corporate Secretary:

THIS CERTIFICATE IS EVIDENCE OF A CONTRACT
BETWEEN THE POLICYHOLDER AND THE COMPANY
READ IT CAREFULLY

For service or complaints about this policy, please address any inquiries to the address shown above or call 866-400-7102.

TABLE OF CONTENTS

NOTE: NO CONTINUOUS COVERAGE. This Certificate of insurance provides coverage for a short term duration only. It is not renewable.

PART I – GENERAL DEFINITIONS

"Accident" means a sudden, unforeseeable event that causes injury to one or more Covered Persons.

"Complications of Pregnancy" means:

1. Conditions requiring Inpatient treatment (when pregnancy is not terminated);
2. Whose diagnoses are distinct from pregnancy but are adversely affected or caused by pregnancy, such as hyperemesis gravidarum, preeclampsia, acute nephritis, nephrosis, cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity, but shall not include false labor, occasional spotting, Doctor prescribed rest during the period of pregnancy, morning Sickness, and other similar conditions associated with the management of a difficult pregnancy not constituting a nosologically distinct complication of pregnancy; and
3. Non-scheduled or emergency cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

"Congenital Condition" means a disease or other anomaly existing at or before birth, whether acquired during development or by heredity.

"Coverage Period" means the length of time which the Insured selected in the Insured's application and approved by us, not to exceed a six (6) month period commencing on the Effective Date. The Insured's Coverage Period is shown in the Schedule of Benefits.

"Covered Person" means an Insured and his eligible dependents for whom coverage is in effect under the policy, as described in Part II – Eligibility and Effective Date of Insurance Provisions and the Schedule of Benefits.

"Custodial or Convalescence Care" means any care that is provided to a Covered Person who is disabled and needs help to support the essential activities of daily living when the Covered Person is not under active and specific medical, surgical, or psychiatric treatment that will reduce the disability to the extent necessary for the person to perform the essentials of daily living on his own.

"Deductible" means the amount of covered expenses that must be paid by a Covered Person before benefits are payable under the policy. This amount applies separately to each Covered Person and must be satisfied each Coverage Period.

"Doctor" means any duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to perform the service for which claim is made.

"Eligible Dependent" means:

1. The Insured's lawful spouse; and
2. The Insured's unmarried children who are less than age 19. An unmarried child who is less than age 25 may also be included if the child is enrolled full-time in an accredited school or college.

Dependent children may include stepchildren, foster children, legally adopted children, children of adopting parents pending finalization of adoption procedures, and children for whom coverage has been court-ordered.

Dependent children (other than those for whom coverage has been court-ordered) must be primarily dependent on the Insured for principal support and maintenance.

Coverage for an unmarried dependent child who is:

A. incapable of self sustaining employment by reason of a physically or mentally disabling injury, illness or condition; who became so incapacitated prior to the attainment of the limiting age set forth above, and

B. chiefly dependent upon the Insured for support and maintenance, shall not terminate. Coverage shall continue as long as the certificate remains in force and the dependent is disabled. Proof of such incapacity and dependency must be furnished to Us within sixty (60) of receipt of notice by Us that such coverage will terminate. We will provide such notice at least 90 days prior to the date the Dependent child attains the limiting age. Continued proof may be requested, but not more frequently than once a year.

“Durable Medical Equipment” means medical equipment that can withstand repeated use, is prescribed by a Physician, and is appropriate for use in the home. Covered DME is limited to a standard basic Hospital bed and/or a standard basic wheel chair.

“Effective Date” means the date the Insured’s (and Eligible Dependents’ if applicable) coverage under the policy is effective.

“Experimental Treatment” means in Our discretion a treatment, drug, device, procedure, supply or service and related services (or any portion thereof, including the form, administration or dosage) for a particular diagnosis or condition when any one of the following exists:

1. The treatment, drug, device, procedure, supply or service is in any clinical trial or a Phase I, II or III trial.
2. The treatment, drug, device, procedure, supply or service is not yet fully approved or recognized (for other than experimental, investigational, research or clinical trial purposes) by the National Cancer Institute (NCI), Food & Drug Administration (FDA), or other pertinent governmental agency or professional organization.
3. The results are not proven through controlled clinical trials with results published in peer-reviewed English language medical journals, to be of greater safety and efficacy than conventional treatment, in both the short and long term.
4. The treatment, drug, device, procedure, supply or service is not generally accepted medical practice in the state where the Covered Person resides or as generally accepted throughout the United States as determined in Our discretion, by reference to any one or more of the following: peer-reviewed English-language medical literature, consultation with physicians, authoritative medical compendia, the American Medical Association, or other pertinent professional organization or governmental agency.
5. The treatment, drug, device, procedure, supply or service is described as investigational, experimental, a study, or for research or the like in any consent, release or authorization which the Covered Person, or someone acting on his or her behalf, may be required to sign.

The fact that a procedure, service, supply, treatment, drug, or device may be the only hope for survival will not change the fact that it is otherwise experimental in nature.

“Extended Care Facility” means an institution, other than a Hospital, operated and licensed pursuant to law, that provides:

1. Permanent and full-time facilities for the continuous skilled nursing care of three (3) or more sick or injured persons on an Inpatient basis during the convalescent stage of their illnesses or injuries;
2. Full-time supervision of a Doctor;
3. Twenty-four (24) hour a day nursing service of one or more Nurses; and
4. Is not, other than incidentally, a rest home or a home for custodial care or for the aged. Extended Care Facility does not include an institution that primarily engages in the care and treatment of drug addiction or alcoholism.

"Home Health Care Agency" means an entity licensed by state or local law operated primarily to provide skilled nursing care and therapeutic services in an individual's home and:

1. Which maintains clinical records on each patient;
2. Whose services are under the supervision of a Doctor or a licensed graduate registered nurse (RN); and
3. Which maintains operational policies established by a professional group including at least one Doctor and one licensed graduate registered nurse (RN).

"Home Health Care Plan" means a program for continued care and treatment of an individual established and approved in writing by the individual's attending Doctor. As part of the plan, an attending Doctor must certify that proper treatment of the Injury or Sickness would require continued confinement in a Hospital in the absence of the services and supplies.

"Hospital" means an institution operated by law for the care and treatment of injured or sick persons; has organized facilities for diagnosis and surgery or has a contract with another hospital for these services; and has 24-hour nursing service. Hospital excludes any institution that is primarily a rest home, nursing home, convalescent home, a home for the aged, an alcoholism or drug addiction treatment facility.

"Immediate Family" means the parents, spouse, children, or siblings of a Covered Person, or any person residing with a Covered Person.

"Injury" means accidental bodily Injury of a Covered Person:

1. Caused by an Accident; and
2. That results in covered loss directly and independently of all other causes.

All Injuries sustained in one Accident, including all related conditions and recurring symptoms of the Injuries, will be considered one injury.

"Inpatient" means a person who incurs medical expenses for at least one day's room and board from a Hospital.

"Insured" means a person who meets the eligibility requirements for an Insured as stated in the Master Application and the policy, and whose coverage under the policy has become effective and has not terminated.

"Medically Necessary" means the care, service or supply is:

1. Prescribed by a Doctor for the diagnosis or treatment of an Injury or Sickness; and
2. Appropriate, according to conventional medical practice for the Injury or Sickness in the locality in which the care, service or supply, is given.

“Mental and Nervous Disorder” means a “biologically-based” mental disorder, including Schizophrenia, Schizoaffective disorder, Major depressive disorder, Bipolar disorder, Paranoia and other psychotic disorders, Obsessive-compulsive disorder, Panic disorder, Delirium and dementia, Affective disorders, and any other "biologically-based" mental disorders appearing in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the "DSM").

“Outpatient” means a person who incurs medical expenses at Doctor’s offices and freestanding clinics, and at Hospitals when not admitted as an Inpatient.

“Regular and Customary Activities” means an Insured Person can carry on a substantial part of the standard and commonly practiced activities of a person in good health of the same sex and age. Activities performed while confined in a Hospital or other medical institution may not be used to meet this requirement.

“Routine Physical Exam” means examination of the physical body by a Doctor for preventive or informative purposes only, and not for the diagnosis or treatment of any condition.

“Sickness” means Sickness or disease of a Covered Person that:

1. Is treated by a Doctor while the person is covered under the policy; and
2. Results directly and independently of all other causes in loss covered by the policy.

“Substance Abuse” means the overindulgence in and dependence on a psychoactive leading to effects that are detrimental to the individual's physical health or mental health, or the welfare of others.

“Surgery or Surgical Procedure” means an invasive diagnostic procedure; or the treatment of Injury or Sickness by manual or instrumental operations performed by a Doctor while the patient is under general or local anesthesia.

“Total Disability” (or “Totally Disabled”) means the Insured is disabled and prevented from performing the material and substantial duties of his or her occupation. For Dependents, “Totally Disabled” means the inability to perform a majority of the normal activities of a person of like age in good health.

“Urgent Care Center” means a medical facility separate from a hospital emergency department where ambulatory patients can be treated on a walk-in basis without an appointment and receive immediate, non-routine urgent care for an Injury or Sickness presented on an episodic basis.

“Usual and Customary” charges means the following:

1. A usual fee is defined as the charge made for a given service by a Doctor to the majority of his or her patients; and
2. A customary fee is one that is charged by the majority of Doctors within a community for the same services. All benefits are limited to Usual and Customary charges.

PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE

Coverage will be effective for an Insured and his Eligible Dependent(s) as of the approved Effective Date, provided:

1. The Insured meets the eligibility requirements set forth in the Master Application and the Policy;
2. The Insured's Application is approved by Us;
3. The first premium payment is received on or before the date the Insured's Application is approved by Us;
4. The Insured is not confined at home or in a Hospital or medical institution as of the Effective date; and
5. The Insured is engaging in his Regular and Customary Activities as of the Effective date.

If the Insured is not engaged in his Regular and Customary Activities or is confined in a Hospital or medical institution on the Effective Date, coverage will begin the first day he can engage in his Regular and Customary Activities and is not confined in a Hospital or medical institution.

The Company will require satisfactory evidence of insurability for each Insured and Eligible Dependent.

Newborn Child Coverage: A child of the Insured born while the policy is in force is covered for Injury and Sickness (including necessary care and treatment of congenital defects, birth abnormality and premature birth), as well as routine newborn care for the first 31 days. The child is covered from the moment of birth until the 31st day of age. A notice of birth together with additional premium must be submitted to us within 31 days of the birth in order to continue coverage for Injury and Sickness beyond the initial 31-day period.

Adopted Children Coverage: A minor child who comes under the charge, care and control of the Insured while the policy is in force is covered for Injury and Sickness provided the Insured files a petition to adopt. The coverage of such child will be the same as provided for other members of the Insured's family. Such child shall be covered from the date of placement in the Insured's home if the Insured applies for coverage and pays any required premium within 31 days after the date of placement. However, coverage shall begin at the moment of birth if the petition for adoption, application for coverage and payment of premium occurs within 31 days after the child's birth. Such child's coverage will not be subject to any pre-existing conditions limitation provided by the policy. Coverage for such minor child will continue unless the petition for adoption is dismissed or denied.

PART III - TERMINATION OF INSURANCE

Coverage of a Covered Person under the Policy shall automatically terminate on the earliest of the following dates:

1. The date the Coverage Period expires;
2. The first day of the month coinciding with or following the date other hospital, major medical, group health or other medical insurance coverage becomes effective for a Covered Person;
3. The end of the last period for which the last required premium payment was made for the Insured's or Covered Person's insurance;
4. The date a Covered Person receives the Coverage Period Maximum Benefit Amount;
5. The date the Covered Person enters the armed forces of any country, state or international organization, other than for reserve duty of 30 days or less;
6. The premium due date that coincides with or next follows the date on which the Insured is no longer eligible;
7. For a Dependent spouse, the first day of the month following the date of divorce or legal separation from the Insured; or
8. The date We specify that the Covered Person's insurance is terminated because of:
   A. Failure to provide any signed release, consent, assignment or other documents requested by Us;
   B. Failure to fully cooperate with Us in the administration of the Policy;
   C. Material misrepresentation, fraud, or omission of information on any application form, or in requesting the receipt of benefits under the Policy; or
   D. Misuse of the Covered Person's identification card.

At the death of an Insured, all rights and privileges as a Covered Person under the Policy will transfer to the surviving Dependent spouse. The Dependent spouse will then be considered an Insured instead of a Dependent. In the event the Dependent spouse remarries, coverage under the Policy for the Dependent Spouse and Dependent child(ren), if any, will end on the first day of the month following the date of that marriage. If no surviving Dependent spouse, or at the death of a surviving Dependent spouse, all rights and privileges as a Covered Person under the Policy will transfer to each Dependent child, if any, and he will be considered the Insured instead of a Dependent.

If the Insured selected the Pay In Advance option in the Insured's Application and We received all required premium for the Coverage Period, premium will be reimbursed to the Insured for the period of time, if any, between the date coverage terminates in accordance with the above provisions and the end of that Coverage Period.

Extension of Benefits

If a covered Bodily Injury or Sickness commences while the Policy is in force as to a Covered Person, benefits otherwise payable under the Policy for the Injury or Sickness causing the Total Disability will also be paid for any Eligible Expenses incurred after the termination of insurance for a Covered Person if, from the date of such termination to the date such expenses are incurred, the Covered Person is Totally Disabled by reason of such Injury or Sickness. Such benefits shall be payable only during the continuance of such disability until the earlier of:

1. The date the Total Disability ends;
2. The date when treatment for the Total Disability is no longer required;
3. The date following a time period equal to the Covered Person's Coverage Period, with a minimum of thirty (30) days not to exceed a maximum of ninety (90) days;
4. The date the Covered Person becomes eligible for any other group insurance plan providing coverage for the same conditions causing the Total Disability; or
5. The date the Coverage Period Maximum Benefit amount has been reached

PART IV - PREMIUMS

1. Unless the Pay In Advance option has been chosen, premium due dates for an Insured will be on the Effective Date and then the same date of each following calendar month. If a month has fewer days than the scheduled premium due date, premium will be due on the last day of the month. All insurance shall be charged from and to the premium due date.
2. If any change or clerical error affects premiums, an equitable adjustment in premiums shall be made on the premium due date next following the date of the change or the discovery of the error. Any premium adjustment that involves collecting earned premiums, or returning unearned premium shall be limited to the six (6) months immediately preceding the date of determination that the adjustment in premium should be made.
3. Premiums shall be payable in advance to Us at Our Home Office.
4. If the Insured has not given written notice to Us that insurance is to be terminated prior to the premium due date, a grace period of thirty-one (31) days beginning from the premium due date will be allowed for any premium after the first premium. If the Insured fails to pay premium before the grace period expires all coverage shall lapse as of the premium due date.
5. The Policy does not share in the surplus earnings of the Company and no refund or assessment shall be made to the Policyholder, Insured, or Dependent of any excess or deficit earnings of the Company.

PART V – DESCRIPTION OF MEDICAL EXPENSES

Subject to the Deductible, Coinsurance and other limits set forth in PART X – SCHEDULE OF BENEFITS, the Company will pay the following expenses incurred while this insurance is in effect:

1. Charges made by a Hospital for:
   - A. Daily room and board and nursing services not to exceed the average semi-private room rate;
   - B. Daily room and board and nursing services in Intensive Care Unit;
   - C. Use of operating, treatment or recovery room;
   - D. Services and supplies which are routinely provided by the Hospital to persons for use while Inpatients;
   - E. Emergency treatment of an Injury, even if Hospital confinement is not required; and
   - F. Emergency treatment of a Sickness; however, an additional $250 Deductible will apply to emergency room charges unless the Covered Person is directly admitted to the Hospital as an Inpatient for further treatment of that Sickness.
2. For Surgery at an Outpatient surgical facility, including services and supplies.
3. For charges made by a Doctor for professional services.
4. For charges made by a Doctor for Surgery. Charges for an assistant surgeon are covered up to 20% of the Usual and Customary charge of the primary surgeon. (Standby availability will not be deemed to be a covered charge.).
5. For dressings, sutures, casts or other supplies which are Medically Necessary and administered by or under the supervision of a Doctor, but excluding nebulizers, oxygen tanks, diabetic supplies, other supplies for use or application at home, and all devices or supplies for repeat use at home, except Durable Medical Equipment as herein defined.
6. For diagnostic testing using radiology, ultrasonographic or laboratory services
(psychometric, intelligence, behavioral and educational testing are not included).
7. For artificial limbs, eyes or larynx, breast prosthesis or basic functional artificial limbs,
but not the replacement or repair thereof.
8. For reconstructive surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease:
   - A. to improve function; or
   - B. to create a normal appearance, to the extent possible.
9. Reconstructive breast surgery and prosthetic devices incident to a Mastectomy. Coverage will also be extended to include surgery on a non-diseased breast to establish symmetry with the diseased breast. As used in this benefit:
   - A. “Mastectomy” means the surgical removal of all or part of a breast as a result of breast cancer.
   - B. “Reconstructive breast surgery” means surgery performed as a result of a mastectomy to reestablish symmetry between the two breasts and includes augmentation mammoplasty, reductive mammoplasty, and mastopexy.

   Coverage for prosthetic devices and reconstructive surgery means any initial or subsequent surgeries, prosthetic devices and any Medically Necessary follow up care.
10. For radiation therapy or treatment and chemotherapy.
11. For hemodialysis and the charges by the Hospital for processing and administration of blood or blood components but not the cost of the actual blood or blood components.
12. For oxygen and other gasses and their administration by or under the supervision of a doctor.

13. For anesthetics and their administration by a Doctor, subject to a maximum of 20% of the benefit payable for the primary surgeon.
14. Extended Care Facility charges for room and board accommodations; if:
    A. The Insured is an Inpatient in that facility on the certification of the attending Doctor that the confinement is Medically Necessary;
    B. The confinement commences immediately following a period of at least three (3) continuous days of Hospital confinement; and
    C. That confinement is for the same covered Injury or Sickness that was treated during the Covered Person's confinement in the Hospital.
15. Treatment of a Covered Person by a Home Health Care Agency under a Home Health Care Plan. Up to four (4) consecutive hours in a twenty-four (24) hour period of Home Health Care services shall be considered as one Home Health Care visit. Eligible Expenses for Home Health Care are the Maximum Allowable Charges made for the following:
    A. Part-time skilled nursing care;
    B. Physical therapy;
    C. Speech therapy;
    D. Medical supplies, drugs and medicines prescribed by a Doctor;
    E. Laboratory services by or on behalf of the Hospital but only to the extent benefits for those services would have been paid under the Policy had the Insured Person remained Hospitalized;
    F. Occupational therapy; and
    G. Respiratory therapy. However, benefits will not be paid for charges made by a Home Health Care Agency for:
    A. Any charges excluded under the Exclusions of the certificate;
    B. Full-time nursing care at home;
    C. Meals delivered to the home;
    D. Homemaker services;
    E. Any services of an individual who ordinarily resides in the Insured's home or is a member of the Insured's immediate family; or
    F. Any transportation services.

    Benefits for Home Health Care are in lieu of any similar benefits provided under any other provision of the certificate.
16. Local Ambulance transport necessarily incurred in connection with Injury, and Local Ambulance transport necessarily incurred in connection with Sickness resulting in Inpatient hospitalization.
17. Dental treatment and dental surgery necessary to restore or replace natural teeth lost or damaged as a result of an Injury covered under this certificate.
18. Medically Necessary rental of Durable Medical Equipment (limited to a standard basic hospital bed and/or a standard basic wheelchair) up to the purchase prices, not including expenses for customization and only for the portion of the cost equivalent to the Coverage Period.
19. Physical Therapy if prescribed by a Doctor who is not affiliated with the Physical Therapy practice, necessarily incurred to continue recovery from a covered Injury or Sickness.

Pre-Certification Requirements

1. All hospitalizations, other Inpatient care, and Surgeries or Surgical Procedures must be Pre-certified.
2. To comply with the Pre-certification requirements, the Covered Person must:

A. Contact the Company at 1-866-400-7102 as soon as possible before the expense is to be incurred; and
B. Comply with the instructions of the Company and submit any information or documents they require; and
C. Notify all Doctors, Hospitals and other providers that this insurance contains Pre-certification requirements and ask them to fully cooperate with the Company.

3. If the Covered Person complies with the Pre-certification requirements, and the expenses are Pre-certified, the Company will pay Eligible Medical Expenses subject to all terms, conditions, provisions and exclusions described in this certificate. If the Covered Person does not comply with the Pre-certification requirements or if the expenses are not Pre-certified:
   A. Eligible Medical Expenses will be reduced by 50%; and
   B. The Deductible will be subtracted from the remaining amount; and
   C. The Coinsurance will be applied.
4. Emergency Pre-certification: In the event of an emergency Hospital admission, Pre-certification must be made within 48 hours after the admission, or as soon as is reasonably possible.
5. Pre-certification Does Not Guarantee Benefits – The fact that expenses are Pre-certified does not guarantee either payment of benefits or the amount of benefits. Eligibility for and payment of benefits are subject to all the terms, conditions, provisions and exclusions herein.
6. Concurrent Review – For Inpatient stays of any kind, the Company will Pre-certify a limited number of days of confinement. Additional days of Inpatient confinement may later be Pre-certified if a Covered Person receives prior approval.

Pre-Certification Requirements for reconstructive surgery in connection with a mastectomy shall not be required in determining length of stay in a hospital following such surgery or procedure. Only a Doctor competent to evaluate the specific clinical issues involved in the care requested, can deny a request to authorize care for reconstructive surgery.

State Mandated Benefits.
The following benefits are mandated by applicable state law. All benefits will be subject to any inside benefit limitations set forth below, as well as the Coverage Period Maximum Benefit amounts shown on the Schedule of Benefits.

1. **Dental Anesthesia** – Coverage shall be provided for general anesthesia for dental care for a Dependent child if an underlying medical condition requires such anesthesia to be provided in a hospital or surgery center setting. Coverage shall only include payment for:
   A. anesthesia; and
   B. hospital or surgery center setting charges.

   The Dependent child must meet the following conditions:
   A. be under the age of seven (7); or
   B. be developmentally disabled, regardless of age; and
   C. it is determined that such child's health is compromised and general anesthesia is Medically Necessary.

2. **Child Preventive Care** - Coverage shall be provided for comprehensive child preventive care consistent with the following for children 16 years of age or younger:
   A. The recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics of September 1987;

B. The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the:
   (a) American Academy of Pediatrics;
   (b) Advisory Committee on Immunization Practices; and
   (c) American Academy of Family Physicians;
   unless the State Department of Health Services determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this benefit provision. and

C. Include benefits for:
   (a) periodic health evaluations;
   (b) immunizations; and
   (c) laboratory services in connection with periodic health evaluations.

3. **Mammography Screening** - Coverage shall be provided for the screening and diagnosis of breast cancer based on the following:
   A. A baseline mammogram for a woman who is thirty-five (35) to forty (40) years of age;
   B. A mammogram for a woman who is forty (40) to forty-nine (49) years of age, every two years, or more frequently, based on the recommendation of the woman's Doctor;

   C. A mammogram each year for a woman who is at least fifty years (50) of age;

4. **Laryngectomy** - Coverage shall be provided for prosthetic devices to restore speech after a laryngectomy.
   As used here:
   Laryngectomy means the Medically Necessary removal of the larynx.

   Prosthetic devices means initial and replacement prosthetic devices, including installation accessories prescribed by a Doctor. It does not include an electronic voice producing machine.

5. **Prostate Screenings** - Coverage shall be provided for the screening and diagnosis of prostate cancer. Coverage shall include, but not be limited to:
   A. prostate specific antigen testing; and
   B. digital rectal examinations.

   Coverage does not include:
   A. radical prostatectomy;
   B. external beam radiation therapy;
   C. radiation seed implants; or
   D. combined hormonal therapy.

6. **Cervical Cancer Screenings** - Coverage shall be provided for an annual cervical cancer screening test including a Pap test or any cervical cancer screening test approved by the FDA and recommended by a Doctor.

7. **Cancer Screening Tests** - Coverage shall be provided for generally medically accepted cancer screening tests.

8. **Phenylketonuria (PKU) Treatment** - Coverage shall be provided for the testing and treatment of phenylketonuria (PKU). Such coverage will include formulas and special food products that are:
   A. part of a diet prescribed by a Doctor;
   B. managed by a health care professional in consultation with a Doctor who specializes in the treatment of metabolic disease.

   Such diet must be Medically Necessary to avoid the development of a serious physical or mental disability; or to promote normal development or function as a consequence of PKU. Coverage is only required to the extent it exceeds the cost of a normal diet.

   As used here:
   "Formula" means an enteral product for use at home that is prescribed or ordered by a Doctor or other authorized health care provider as Medically Necessary for the treatment of PKU.

   "Special food products" means a food product that is both:
   A. prescribed by a Doctor for the treatment of PKU and consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, PKU. It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving; and
   B. used in place of normal food products, such as grocery store foods , used by the general population.

9. **Osteoporosis** - Coverage shall be provided for the diagnosis, treatment and appropriate management of osteoporosis. Coverage will include, but not be limited to, FDA approved technologies such as bone mass measurement, as deemed medically appropriate.

10. **Severe Mental Illness/Serious Emotional Disturbances of a Child** - Coverage for Medically Necessary treatment shall be provided for:
   A. diagnosis and treatment of severe mental illness for a Covered Person of any age; and
   B. emotional disturbances of a child who:
      (a) has one or more mental disorders as identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or developmental disorder, that result in behavior inappropriate to such child's age according to expected development norms; and
      (b) meets one or more of the following:
         (i) displays psychotic features, risk of suicide, or risk of violence due to a mental disorder; or
         (ii) meets special education eligibility requirements pursuant to California state law; or
         (iii) has substantial impairment, as a result of the mental disorder, in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and either of the following occur: the child is at risk of removal from his/her home or has already been removed from the home; or the

mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment.

Benefits shall include charges incurred for:

1. Outpatient services;
2. Inpatient hospital services, including inpatient prescription drugs and
3. Partial hospital services.

As used here:
"Severe mental illness" shall include:

1. Schizophrenia or schizoaffective disorder; or
2. Bipolar disorder (manic-depressive illness); or
3. Major depressive disorder; or
4. Panic disorder; or
5. Obsessive-compulsive disorder; or
6. Pervasive developmental disorder or autism; or
7. Anorexia nervosa or bulimia nervosa.

11. **Diabetes** - Coverage shall be provided for Medically Necessary supplies, equipment and management and treatment of insulin using diabetes, non-insulin using diabetes and gestational diabetes. Coverage shall include:

A. Blood glucose monitors, including glucose monitors for the visually impaired;
B. Blood glucose test strips, ketone urine testing strips;
C. Insulin pumps and related necessary supplies;
D. Lancets and lancet puncture devices;
E. pen delivery systems for the administration of insulin;
F. Podiatric devices to prevent or treat diabetes related complications;
G. Insulin syringes;
H. Visual aids (but not eyewear) to assist the visually impaired with proper dosing of insulin.

Coverage shall also include outpatient self-management training, education and medical nutrition therapy services necessary to enable the Covered Person to properly use the equipment and supplies listed above. Such services must be provided by an appropriately licensed or registered health care professional as prescribed by a health care professional legally authorized to prescribe the services.

12. **AIDS Vaccine** – Coverage shall be provided for a vaccine for Acquired Immune Deficiency Syndrome (AIDS) that is approved by the FDA and recommended by the U.S. Public Health Service.

13. **Cancer Clinical Trials** - Coverage shall be provided for routine patient costs for a Covered Person diagnosed with cancer and accepted into a phase I, phase II, phase III, or phase IV clinical trial for cancer. The Covered Person's Doctor must recommend participation in the clinical trial and determine that it will have a meaningful potential benefit. Treatment must be provided in a clinical trial that:

A. involves a drug that is exempt under federal regulations from a new drug application; or
B. is approved by one of the following:
   (a) one of the National Institutes of Health (NIH);

(b) the FDA, in the form of an investigational new drug application;
(c) the U.S. Department of Defense; or
(d) the U.S. Veterans' Administration.

"Routine patient costs" means costs associated with the provision of health care services, including drugs, items, devices, and services that would otherwise be covered under the plan or contract if those drugs, items, devices, and services were not provided in connection with an approved clinical trial program, including the following:

A. Health care services typically provided absent a clinical trial.
B. Health care services required solely for the provision of the investigational drug, item, device, or service.
C. Health care services required for the clinically appropriate monitoring of the investigational item or service.
D. Health care services provided for the prevention of complications arising from the provision of the investigational drug, item, device, or service.
E. Health care services needed for the reasonable and necessary care arising from the provision of the investigational drug, item, device, or service, including the diagnosis or treatment of the complications.

It does not include:

A. drugs or devices not approved by the FDA and that are associated with the clinical trial;
B. services other than health care services, such as travel, housing, companion expenses and other nonclinical expenses;
C. any item or service that is provided solely to satisfy data collection and analysis needs and that is not used in the clinical management of the patient.
D. health care services which, except for the fact that they are not being provided in a clinical trial, are otherwise specifically excluded under this certificate; or
E. health care services customarily provided by the research sponsors free of charge for any enrollee in the trial.

PART VI – EXCLUSIONS

Charges for the following treatments and/or services and/or supplies and/or conditions are excluded from coverage:

1. Pre-existing Conditions – Charges resulting directly or indirectly from a condition for which a Covered Person received medical treatment, diagnosis, care or advice within the six (6) month period immediately preceding such person's Effective Date are excluded for the first six (6) months of coverage hereunder. A Covered Person who was covered under creditable coverage within 63 days of enrolling under this certificate shall be given credit for the period of time under such coverage toward the satisfaction of this exclusion. This exclusion does not apply to a newborn or newly adopted child who is added to coverage under this certificate in accordance with PART II – ELIGIBILITY AND EFFECTIVE DATE OF INSURANCE. Creditable Coverage means any of the following:
   - A. A group health plan; or
   - B. Health insurance coverage (care under any hospital or medical service policy or certificate; hospital or medical service plan contract; or Health Maintenance Organization (HMO); or
   - C. Individual coverage; or
   - D. Medicare; or
   - E. Medicaid; or
   - F. CHAMPUS; or
   - G. A medical care program of the Indian Health Service or of a tribal organization; or
   - H. A State health benefits risk pool; or
   - I. A health plan offered under the Federal Employees Health Benefits Program (FEHBP); or
   - J. A public health plan; or
   - K. A health benefit plan under the Peace Corps Act.

   Creditable coverage does not include accident only, credit, coverage for onsite medical clinics, disability income, Medicare supplement, long-term care insurance, dental, vision, coverage issued as a supplement to liability insurance, workers' compensation insurance or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

   Any coverage under which an insured was covered prior to a break in coverage of 63 consecutive days or more, not counting any waiting period or affiliation period required by any Creditable Coverage, will not be considered Creditable Coverage.
2. Outpatient Prescription Drugs, medications, vitamins, and mineral or food supplements including pre-natal vitamins, or any over-the-counter medicines, whether or not ordered by a Doctor.
3. Routine pre-natal care, Pregnancy, childbirth, and postnatal care. (This exclusion does not apply to "Complications of Pregnancy" as defined.)
4. Alcoholism.
5. Substance abuse.
6. Charges which are not incurred by a Covered Person during his/her Coverage Period.
7. Treatment, services or supplies, which are not administered by or under the supervision of a Doctor.
8. Treatment, services or supplies which are not Medically Necessary as defined.
9. Treatment, services or supplies provided at no cost to the Covered Person.

10. Charges which exceed Usual and Customary charge as defined.
11. Telephone consultations or failure to keep a scheduled appointment.
12. Consultations and/or treatment provided over the Internet.
13. Surgeries, treatments, services or supplies which are deemed to be Experimental Treatment.
14. All charges Incurred while confined primarily to receive Custodial or Convalescence Care.
15. Weight modification or surgical treatment of obesity, including wiring of the teeth and all forms of intestinal bypass surgery.
16. Modifications of the physical body in order to improve the psychological, mental or emotional well-being of the Covered Person, such as sex-change surgery.
17. Surgeries, treatments, services or supplies for cosmetic or aesthetic reasons, except for reconstructive surgery which is expressly covered under this certificate.
18. Any drug, treatment or procedure that either promotes or prevents conception including but not limited to: artificial insemination, treatment for infertility or impotency, sterilization or reversal of sterilization.
19. Any drug, treatment or procedure that either promotes, enhances or corrects impotency or sexual dysfunction.
20. Abortions, except in connection with covered Complications of Pregnancy or if the life of the expectant mother would be at risk.
21. Dental treatment, except for dental treatment that is expressly covered under this certificate.
22. Eyeglasses, contact lenses, hearing aids, hearing implants, eye refraction, visual therapy, and any examination or fitting related to these devices, and all vision and hearing tests and examinations.
23. Eye surgery, such as radial keratotomy, when the primary purpose is to correct nearsightedness, farsightedness or astigmatism.
24. Treatment for cataracts.
25. Treatment of the temporomandibular joint, except for medically necessary surgical procedures for covered conditions directly affecting the upper or lower jawbone or associated bone joints.
26. Injuries resulting from participation in any form of skydiving, scuba diving, auto racing, bungee jumping, hang or ultra light gliding, parasailing, sail planing, flying in an aircraft (other than as a passenger on a commercial airline), rodeo contests or as a result of participating in any professional, semi-professional or other non-recreational sports including boating, motorcycling, skiing, riding all-terrain vehicles or dirt-bikes, snowmobiling or go-carting.
27. Injuries or Sicknesses resulting from participation in interscholastic, intercollegiate or organized competitive sports.
28. Injury resulting from being under the influence of or due wholly or partly to the effects of alcohol or drugs, other than drugs taken in accordance with treatment prescribed by a Doctor, but not for the treatment of Substance Abuse.
29. Willfully self-inflicted Injury or Sickness.
30. Immunizations and Routine Physical Exams, except as expressly covered under this certificate or under a Rider attached to this certificate.
31. Services received for any condition caused by a Covered Person's commission of or attempt to commit a felony or to which a contributing cause was the Covered Person being engaged in an illegal occupation.
32. Speech, vocational, occupational, biofeedback, acupuncture, recreational, sleep or music therapy, holistic care of any nature, massage and kinestherapy.

33. Any services performed or supplies provided by a member of the Insured's Immediate Family.
34. Orthoptics and visual eye training.
35. Services or supplies which are not included as Eligible Expenses as described herein.
36. Care, treatment or supplies for the feet: orthopedic shoes, orthopedic prescription devices to be attached to or placed in shoes, treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions, and treatment of corns, calluses or toenails.
37. Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Doctor.
38. Treatment of sleep disorders.
39. Hypnotherapy when used to treat conditions that are not recognized as Mental or Nervous Disorders by the American Psychiatric Association, and biofeedback, and non-medical self-care or self-help programs.
40. Any services or supplies in connection with cigarette smoking cessation.
41. Exercise programs, whether or not prescribed or recommended by a Doctor.
42. Treatment required as a result of complications or consequences of a treatment or condition not covered under this certificate.
43. Charges for travel or accommodations, except as expressly provided for local ambulance.
44. Treatment incurred as a result of exposure to non-medical nuclear radiation and/or radioactive material(s).
45. Organ or Tissue Transplants or related services.
46. Treatment for acne, moles, skin tags, diseases of sebaceous glands, seborrhea, sebaceous cyst, unspecified disease of sebaceous glands, hypertrophic and atrophic conditions of skin, nevus.
47. Services received or supplies purchased outside the United States, its territories or possessions, or Canada.
48. Treatment for or related to any congenital condition, except as it relates to a newborn or adopted child added as a Covered Person to this certificate.
49. Spinal manipulation or adjustment.
50. Sclerotherapy for veins of the extremities.
51. Expenses during the first 6 months after the Effective Date of coverage for a Covered Person for the following (subject to all other coverage provisions, including but not limited to the Pre-existing Condition exclusion):
    A. Total or partial hysterectomy, unless it is Medically Necessary due to a diagnosis of carcinoma;
    B. Tonsillectomy;
    C. Adenoidectomy;
    D. Repair of deviated nasal septum or any type of surgery involving the sinus;
    E. Myringotomy;
    F. Tympanotomy;
    G. Herniorrhaphy; or
    H. Cholecystectomy.
52. Chronic fatigue or pain disorders.
53. Treatment or diagnosis of allergies, except for emergency treatment of allergic reactions.
54. Treatment, medication or hormones to stimulate growth, or treatment of learning disorders, disabilities, developmental delays or deficiencies, including therapy.
55. Kidney or end stage renal disease.
56. Joint replacement or other treatment of joints, spine, bones or connective tissue including tendons, ligaments and cartilage, unless related to a covered Injury.

57. Expenses resulting from a declared or undeclared war, or from voluntary participation in a riot or insurrection.
58. Expenses incurred by a Covered Person while on active duty in the armed forces. Upon written notice to Us of entry into such active duty, the unused premium will be returned to the Covered Person on a pro-rated basis.

PART VII – COORDINATION OF BENEFITS (COB)

Some people have health care coverage through more than one medical insurance plan at the same time. COB allows these plans to work together so the total amount of all benefits will never be more than 100 percent of the allowable expenses during any coverage year. This helps to hold down the costs of health coverage.

COB does not apply to life insurance or accidental death and dismemberment benefits.

The term "plan" applies separately to each policy, contract agreement or other arrangements for benefits or services. The term "plan" also applies separately to that part of any policy, contract, agreement or other arrangements for benefits or services that coordinates its benefits with other plans and to that part that does not.

When a plan provides benefits in the form of services rather than cash payment the reasonable cash value of each service rendered will be considered to be both: (1) an allowable expense; and (2) a benefit paid.

Definitions. "Plan" – means any of the following which provides benefits or services for medical expenses:

1. Any group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice, or individual practice coverage.
2. Any federal, state or local governmental programs, or coverage required or provided by law. This does not include a state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time.)

Each contract or other arrangement for coverage under the above paragraphs is a separate plan. Also, if an arrangement has two parts and COB rules apply to one of the two, each of the parts is construed to mean a separate Plan.

The term "plan" does not include:

1. Individual or family insurance or subscriber contracts;
2 Individual or family coverage through Health Maintenance Organizations (HMOs);
3. Individual or family coverage under other prepayment, group practice and individual practice plans;
4. School accident-type coverages. (These contracts cover students for accidents only, including athletic injuries, either on a twenty-four hour basis or on a to-and-from school basis);
5. Group or group-type hospital indemnity benefits of $100 per day or less;
6. Medicare Supplement policies;
7. A state plan under Medicaid.

"Primary Plan (Primary)" – means the Plan which determines its benefits before those of the other Plan. When there are more than two (2) Plans, This Plan may be Primary as to one and Secondary as to another.

"Secondary Plan (Secondary)" – means the Plan which determines its benefits after those of the other Plan. When there are more than 2 Plans, This Plan may be Secondary as to one and Primary as to another.

"This Plan" – means the benefits provided under this group policy.

Effect on Benefits. Plans use COB to decide which plan should pay first for a covered expense. If the Primary Plan's payment is less than the charge for the allowable expense, then the Secondary Plan will apply its benefit payment to the balance.
The following rules will be used to establish the order of benefit determination:

1. A plan which does not have a COB provision will always be the Primary Plan.
2. The benefits of a plan which covers the person on whose expenses the claim is based as other than a dependent will be determined before the benefits of a plan which covers the person as a dependent. However, if the person is also a Medicare beneficiary, and if the rule established under the Social Security Act of 1965, as amended, makes Medicare secondary to the plan covering the person as a dependent of an active employee, the order of benefit determination is:
   A. First, benefits of a plan covering persons as an employee, member, or subscriber.
   B. Second, benefits of a plan of an active worker covering persons as a dependent.
   C. Third, Medicare benefits.
3. The benefits of a plan that covers a person for whom a claim is made as a dependent child will be determined under the following rules:
   A. When the parents are married: the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs earlier in the calendar year will be determined before the benefits of a plan which covers the child as a dependent of the parent whose birthday anniversary occurs later in the calendar year.
   B. If both parents have the same birthday the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time.
   C. If the plans do not agree on the order of benefit rules because the other plan does not have the rule described in this section, but has a rule based upon the gender of the parent, the rule in the other plan will determine the order of benefits.
   D. When the parents are separated or divorced and the parent with custody has not remarried the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
   E. When the parents are divorced and the parent who has custody of the child has remarried: (a) the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the step-parent; and (b) the benefits of a plan that covers the child as a dependent of the step-parent will be determined before the benefits of a plan that covers the child as a dependent of the parent without custody.
   F. Despite (2) and (3) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, the benefit payment of a plan which covers the child as a dependent of the parent with such financial responsibility will be determined before the benefit payment of any other plan that covers the child as a dependent child.
4. The benefits of a plan that covers a person as a primary insured who is neither laid off nor retired, or as that primary insured's dependent, are determined before those of a plan that covers that person as a laid off or retired primary insured or as that primary

insured's dependent. This rule will not apply if the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits.

5. If a person whose coverage is provided under a right of continuation pursuant to federal or state law is covered under another plan, the following will be the order of benefit determination:
   A. First, the benefits of a plan covering the person as an employee, member, or subscriber (or as that person's dependent);
   B. Second, the benefits under the continuation coverage. If the other plan does not have the rule described above and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

6 When rules 2 through 5 do not establish an order of benefit determination the benefits of a plan which has covered the person on whose expenses the claim is based for the longer period of time will be determined before the benefits of a plan which has covered the person the shorter period of time.

Facility of Payment. If another plan makes a benefit payment that should have been made by us we have the right to pay the other plan any amount we deem necessary to satisfy our obligation under these COB rules.

Right of Recovery. If the amount of our benefit payment is more than the amount needed to satisfy our obligation under these COB rules, we have the right to recover the excess amount from: (A) any persons to or for whom, or with respect to whom, the payments were made; (B) any insurance companies; or (C) any other organizations.

Right to Receive and Release Necessary Information. In order to carry out these COB rules:

1. We have the right, without the consent of or notice to any person, to exchange information with any person, insurance company or organization, as we deem necessary; and
2. Any person claiming benefits under this plan must give us any information necessary to carry out this provision.

PART VIII - CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given within 31 days after a covered loss begins or as soon as is reasonably possible. The notice must be given to the Company named on the Schedule of Benefits. Notice should include information that identifies the claimant and the policy.

Claim Forms: When the Company receives notice of claim, forms for filing proof of loss will be sent to the claimant. If claim forms are not supplied within 15 days, a claimant can give proof as follows:

1. In writing;
2. Setting forth the nature and extent of the loss; and
3. Within the time stated in the Proof of Loss provision.

Proof of Loss: Written proof of loss must be given to the Company within 90 days after the loss begins. We will not deny nor reduce any claim if it was not reasonably possible to give proof of loss in the time required. In any event, proof must be given to the Company within one year after it is due unless the Insured is legally incapable of doing so.

Time of Payment of Claim: Benefits for loss covered by the policy will be paid as soon as we receive proper written proof of such loss, but no later than 30 working days after We receive Proof of Loss.

Payment of Claims: All benefits will be paid to the Insured, if living, unless an Assignment of Benefits has been requested by the Insured. Any other benefits due and unpaid at the Insured's death will be paid to the Insured's estate. If a benefit is to be paid to the Insured's estate, or to an Insured or beneficiary who is not competent to give a valid release, the Company may pay up to $1,000.00 of such benefit to one of the Insured's relatives who is deemed by the Company to be justly entitled to it. Such payment, made in good faith, fully discharges the Company to the extent of the payment.

Physical Examination: At our expense, we may have a person claiming benefits examined as often as reasonably necessary while the claim is pending.

Legal Action: No legal action may be brought to recover on the policy before 60 days after written proof of loss has been furnished as required by the policy. No such action may be brought after three years from the time written proof of loss is required to be furnished.

Third Party Liability: No benefits are payable for any Sickness, Injury, or other condition for which a third party may be liable or legally responsible by reason of negligence, an intentional act, or breach of any legal obligation on the part of such third party. Nevertheless, the Company will advance the benefits of this policy to the Insured subject to the following**:**

1. The Insured agrees to advise Us, in writing, within 60 days of any Covered Person's claim against the third party and to take such action, provide such information and assistance, and execute such paper as We may require to facilitate enforcement of the claim. The Insured and Covered Person also agree to take no action that may prejudice Our rights or interests under this policy. Failure to provide notice of a claim or to cooperate with Us, or actions that prejudice Our rights or interests, will be material breach of this policy and will result in the Insured being personally responsible for reimbursing Us.

2 We will automatically have a lien, to the extent of benefits advanced, upon any recovery that any Covered Person receives from the third party, the third party's insurer, or the third party's guarantor. Recovery may be by settlement, judgment or otherwise. The lien will be in the amount of benefits paid by Us under this policy for the treatment of the Sickness, disease, Injury or condition for which the third party is liable.

Independent Medical Review: A Covered Person, or a representative acting on his or her behalf, has the right to request an independent medical review whenever healthcare services have been denied, modified or delayed by Us, if the decision was based in whole or in part on a finding that the proposed health care services are not medically necessary. A doctor, or other health care provider, may assist in seeking an independent medical review and may advocate on such Covered Person's behalf.

PART IX – GENERAL PROVISIONS

Time Limit on Certain Defenses: The validity of coverage issued under the Policy with respect to an Insured or his Eligible Dependents may not be contested after three years from each certificate's effective date, except for nonpayment of premiums.

Misstatement of Age: If the age of any Covered Person is incorrectly stated, we will make a fair adjustment of the premiums, benefits or both. The adjustment will be based on the premiums and benefits that would have been payable had we known the correct information.

Not in Lieu of Workers' Compensation: The policy is not in lieu of and does not affect requirements for coverage under Workers' Compensation laws.

Pronouns: Whenever a personal pronoun in the masculine gender is used, it will be deemed to include the feminine also, unless the context clearly indicates to the contrary.

PART X – SCHEDULE OF BENEFITS

INSURED INFORMATION:

Name: Steven Buckley

Policy Effective Date: 4/1/2016

COVERAGE PERIOD: 6 Months

ELIGIBILE DEPENDENTS COVERED Danielle Buckley, [redacted], [redacted]

COVERAGE AND BENEFIT AMOUNTS:

Deductible	$7,500 per Covered Person per Coverage Period. Maximum of 3 Deductibles per family per Coverage Period. An additional Deductible of $250 per visit will be applied to charges for use of emergency room in the event of Sickness unless the Covered Person is directly admitted as an Inpatient for further treatment.
Coinsurance	During a Coverage Period, the Company will pay 50% of the next $5,000 of Eligible Expenses after the Deductible, then 100% of Eligible Expenses to the Overall Maximum Limit.
Urgent Care Center	For each visit, the Covered Person shall be responsible for a $50 co-payment, after which Coinsurance will apply. Not subject to Deductible
Hospital Room and Board	Average Semi-private room rate, including nursing services.
Local Ambulance	Injury: Usual and Customary charges to a Maximum of $250 per trip, when related to a covered Injury. Sickness: Usual and Customary charges to a maximum of $250 per trip, when covered Sickness results in hospitalization as Inpatient
Intensive Care Unit	Usual and Customary charges
Physical Therapy	$50 Maximum per visit per day
Home Health Care	Maximum 1 visit per day. Maximum of 40 visits during a Coverage Period
Extended Care Facility	Not to exceed a daily rate of $150 nor a maximum of 60 days

All Other Eligible Medical Expenses	Usual and Customary charges
Penalty for Failure to Pre-certify	50% of Eligible Medical Expenses
Overall Maximum Limit per Coverage Period	$2,000,000

HCC Life STM Enrollment Form

For use in CA

HCC Life Insurance Company

(Herein referred to as HCC Life)

Please submit completed applications with payment to:

HCC Life Insurance Company
251 N. Illinois Street, Suite 600
Indianapolis, IN 46204

- Please complete this application entirely. Failure to provide complete information may delay processing.
- You may elect the $5,000 and $7,500 deductible options by applying online or contacting us.

Personal Details Please provide the following details for all individuals to be covered.

Name (First and Last)	Date of Birth	Gender	Contact Information
Primary *Steven Buckley*	*2/24/*[redacted]	☒ Male ☐ Female	Address [redacted]
Spouse *Danielle Buckley*	*4/25/*[redacted]	☐ Male ☒ Female	City [redacted] State [redacted] Zip [redacted]
Child 1 [redacted]	*8/19/*[redacted]	☐ Male ☒ Female	Phone Number [redacted]
Child 2 [redacted]	*9/30/*[redacted]	☐ Male ☒ Female	E-mail Address [redacted]

Plan Options Please check the boxes corresponding to your elections for deductible and coinsurance.

Deductible ☐ $250 ☐ $500 ☐ $1,000 ☐ $2,500 ☒ $7500

Coinsurance ☐ 80% of $5,000 ☒ 50% of $5,000

Requested Effective Date *4* / *1* / *2016*

Payment Option

☒ Monthly – 6 month plan

☐ Single Up Front (please specify term date)
Specify Term Date _____
Number of days (max 180) _____

Medical Questions Please answer the questions below as they apply to the Applicant (Primary person listed above) applying for coverage. For each family member applying for coverage, complete and answer the questions on the Dependent Medical Questionnaire.

1. Will you have other health insurance in force on the policy effective date or be eligible for Medicaid?	☐ Yes ☒ No
2. Have you: a. Been denied insurance due to any health reasons for a condition that is still present? b. Now pregnant, in process of adoption or undergoing infertility treatment? c. Over 300 pounds if male or over 250 pounds if female?	☐ Yes ☒ No
3. Within the last 5 years have you been diagnosed, treated, or taken medication for any of the following: cancer or tumor, stroke, heart disease including heart attack, chest pain or had heart surgery, COPD (chronic obstructive pulmonary disease) or emphysema, Crohn's disease, liver disorder, degenerative disc disease or herniation/bulge, rheumatoid arthritis, kidney disorder, diabetes, degenerative joint disease of the knee, alcohol abuse or chemical dependency, or any neurological disorder?	☐ Yes ☒ No
4. Within the last 5 years have you been diagnosed or treated by a physician or medical practitioner for Acquired Immune Deficiency Syndrome (AIDS)?	☐ Yes ☒ No
5. If you are not a US Citizen, do you expect to legally reside in the US for the duration of the policy?	☐ Yes ☐ No ☒ US citizen

If you have answered "Yes" to questions 1 through 4 or "No" to question 5 above, coverage cannot be issued. Thank you for your interest.

California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

For product information or assistance with this enrollment form, please contact:

Healthy Halo Insurance Services, Inc.
800-788-2197
brent@healthyhalo.com

Rate Calculation

Use the rate table corresponding to your choice of plan option and coinsurance level to complete applicant rates below, then follow the calculation instructions.

			Monthly Payments	Single Up-front Payment
A	Applicant's Rate		A ***128.16***	A
B	Spouse's Rate		B ***96.92***	B
C	Per child ***21.72*** x # ***2*** =		C ***43.44***	C
D	A + B + C =		D ***268.52***	D
E	Zip Code Factor		E ***2.4600***	E
F	D x E = Monthly / Daily Premium Total (round to the nearest penny)		F ***$660.56***	F
G	Monthly / Daily Association Fee		G $5.00	G
H	F + G = Total Monthly / Daily Rate		H ***665.56***	H
I	Number of Months to be Covered		***n/a***	I
J	H x I =		***n/a***	J
K	Administrative Fee		K $10.00	K $10.00
L	**Total Due**	**Monthly:** H + K= **Daily:** J + K =	L ***$675.55***	L

Payment Information

Please provide complete payment information. Applications without payment cannot be processed.

☐ **Check/Money Order** (Single Up-Front Payment Only) ☐ **MasterCard** ☒ **VISA** ☐ **Discover** ☐ **American Express**

Credit Card Number	Exp Date
xxxxxxxxxxxx7403	***1/2019***

Name on Card
Steven Buckley

Pho[redacted]

Billing Address (including city, state and zip)
[redacted]

Check or Money Orders should be made payable, in US dollars, to HCC Life Insurance Company. If paying by credit card, I authorize HCC Life to debit my Discover, VISA, MasterCard or American Express account for the amount specified in the Rate Calculation section. If I have selected a monthly plan, I hereby request and authorize HCC Life to debit my Credit Card account for the proper installment amounts on the due dates of the installments. This authorization will remain in effect for the duration of the Coverage Period elected or until revoked by me in writing. Coverage purchased by credit card is subject to validation and acceptance by the credit card company.

Cardholder Signature	Date
Signed Electronically	***3/31/2016***

Authorization

I hereby request coverage under the insurance issued to the Consumer Benefits of America Association and underwritten by HCC Life Insurance Company. I understand this insurance contains a Pre-existing Condition exclusion, a Pre-certification Penalty and other restrictions and exclusions. I agree that coverage will not become effective for me or any dependent whose medical status, prior to the effective date, has changed and therefore results in a "yes" answer to any of the medical questions on this application. If my medical status changes in this way, coverage will be declined for all individuals included on this application. I understand that if I have elected the Monthly Payment option, my credit card will be charged each month on the due date of the premium for 6 months, depending on the plan I have selected. I understand that I may terminate the scheduled payments by notifying HCC Life in writing at least one business day prior to the next scheduled payment date. I understand that this coverage is not renewable or extendable. I understand that the information contained herein is a summary of the coverage offered in the Certificate of Insurance and that I may obtain a complete copy of the Certificate of Insurance upon request to HCC Life. I understand that HCC Life, as underwriter of the plan, is solely liable for the coverage and benefits provided under the insurance. I understand and agree that the insurance agent/broker, if any, assisting with this application is a representative of the Applicant. If signed by a representative of the Applicant, the undersigned represents his/her capacity to so act. If signed as guardian or proxy of the Applicant, the undersigned represents his/her capacity to so act. By acceptance of coverage and/or submission of any claim for benefits, the Applicant ratifies the authority of the signer to so act and bind the Applicant. If I am not already a member of the Consumer Benefits of America Association, I hereby request to be enrolled as a member. I will receive a membership packet after my membership fees of $5 per month are received. Fraud Warning: Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person submits an insurance application or statement of claim containing any materially false, incomplete or misleading information may be committing a crime and may be subject to civil or criminal penalties.

Applicant Signature	Date	Spouse Signature	Date
Signed Electronically	***3/31/2016***	***Signed Electronically***	***3/31/2016***

Signed by HCC Life Appointed Agent:	Plan Administrator Use Only:	
	PBC 6CA.110.07.09	Code: ***236011180B***

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Privacy Promise

We will keep your medical information private. We will also give you this notice about our privacy practices, our legal duties and your rights concerning your medical information. We will follow the privacy practices that we describe in this notice while it is in effect. This notice took effect April 14, 2003, and will remain in effect until it is changed or replaced.

We reserve the right to change our privacy practices and the terms of this notice at any time, as long as the law allows. We reserve the right to make these changes effective for all medical information that we keep, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice accordingly and send the new notice to you prior to the effective date of the change.

You may request a copy of this notice at any time or view a copy on our Web site at www.hcclife.com.

Uses and Disclosures of Medical Information

Treatment, Payment, Health Care Operations

We may use and disclose your medical information for purposes of treatment, payment and health care operations. For example:

Treatment: We may disclose your medical information to a physician or other health care professional so they can treat you.

Payment: We may use and/or disclose your medical information for these and other related activities:

- To pay claims from physicians, hospitals and other health care professionals for covered services you received.
- To determine your eligibility for benefits.
- To coordinate those benefits.
- To determine medical necessity.
- To obtain premiums.
- To issue explanations of benefits to the named insured.

We may also disclose your medical information to a health care professional or entity that is bound by the federal Privacy Rules so they can obtain payment or engage in payment activities.

Health Care Operations: We may use and/or disclose your medical information in the normal course of our health care operations. This includes:

- Determining our risk and premiums for your health plan.
- Quality assessment and improvement activities.
- Reviewing the qualifications of health care professionals; evaluating practitioner and provider performance; conducting training programs; and accreditation, certification, licensing and credentialing activities.
- Medical review, legal services and auditing, including fraud and abuse detection and compliance programs.
- Business planning and development.
- Business management and general administrative activities, including management activities relating to privacy, customer service, internal grievances and creating de-identified information or a limited data set.

We may disclose your medical information to another entity, which has a relationship with you and is also bound by the federal Privacy Rules, for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, or detecting or preventing health care fraud and abuse.

Your Authorization

You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. You may revoke your authorization in writing at any time. However, this will not affect any uses and disclosures we made while your authorization was in effect. Without your written authorization, we will not use or disclose your medical information for any reason except those described in this notice.

Your Family and Friends

We may disclose your medical information to a family member, friend or other person to the extent necessary for them to assist with your health care, or with payment for your health care. We may also use or disclose your medical information to notify (or help notify, including identifying and locating) a family member, a personal representative or other person responsible for your care of your location, general condition or death.

Before we disclose your medical information to that person, we will give you a chance to object to us doing so. If you are not available, or if you are incapacitated or in an emergency situation, we will disclose your medical information based on our professional judgment of what would be in your best interest.

Your Employer or Organization Sponsoring Your Group Health Plan

We may disclose summary information about you to your employer or plan sponsor for two reasons. One is to get premium bids for the health insurance coverage offered

through your group health plan. The second is to decide whether to modify, amend or terminate your group health plan. The summary information we may disclose summarizes claims history, claims expenses or types of claims members of your group health plan have filed. The summary information will not include demographic information about the people in the group health plan, but your employer or plan sponsor may be able to identify you or others from the summary information.

Underwriting
We may receive your medical information for underwriting, premium rating or other activities necessary to create, renew or replace a contract of health insurance or health benefits. We will not use or further disclose this medical information for any other purpose (except as required by law) unless the contract of health insurance or health benefits is placed with us, in which case we will use and disclose your medical information as described in this notice.

Disaster Relief
We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit
We may use or disclose your medical information as authorized by law for the following purposes that are in the public interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistics reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury.
- To report adult abuse, neglect or domestic violence.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.
- To law enforcement officials in response to subpoenas and other lawful processes concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies and to identify or locate a suspect or other person.
- To coroners, medical examiners and funeral directors.
- To organ procurement organizations.
- To avert a serious threat to health or safety.
- In connection with certain research activities.
- To the military and to federal officials for lawful intelligence, counterintelligence and national security activities.
- To correctional institutions regarding inmates.
- As authorized by state workers' compensation laws.

Health-Related Services
We may use your medical information to contact you about health-related benefits and services, or about treatment alternatives. We may disclose your medical information to a business associate to assist us in these activities.

Marketing
We may use or disclose your medical information to encourage you to purchase or use a product or service by face-to-face communication, or to provide you with promotional gifts of nominal value.

Individual Rights

Access
You have the right to inspect or get copies of your medical information, with some exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical to do so. To get your medical information, you must make a request in writing. If you request copies, we will charge you $0.50 for each page and for staff time to copy your medical information. We also will charge for postage if you want us to mail the copies to you. If you request another format, we will charge a cost-based fee for providing your medical information in that format. Contact us using the information listed at the end of this notice for a full explanation of our fees.

Disclosure Accounting
You have the right to request, in writing, to receive a list of instances in which we (or our business associates) disclosed your medical information for purposes other than treatment, payment and health care operations, or as authorized by you, or for certain other activities allowed by law, on or after April 14, 2003. We will provide you with the date on which we made each disclosure, the name of the person or entity to which we disclosed your medical information, a description of the medical information we disclosed and the reason for the disclosure. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for each additional request. Contact us using the information listed at the end of this notice for a full explanation of our fees.

Restriction
You have the right to request, in writing, that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement for us. We will not be bound unless our agreement is in writing.

Confidential Communications
You have the right to request, in writing, that we communicate with you about your medical information by other means, or to other locations. You must state that you could be in danger if we do not communicate to you in confidence. We must accommodate your request if it is reasonable, if it specifies the other means or location, and if it permits us to continue to collect premiums and pay claims under your health plan. This includes sending explanations of benefits to the named insured of your health plan. We will not be bound to your confidential communications request unless our agreement is in writing.

Even though you requested that we communicate with you about your health care in confidence, an explanation of benefits issued to the named insured for health care that the named insured (or others covered by the health plan) received might contain sufficient information, such as deductible and out-of-pocket amounts, to reveal that you obtained health care for which we paid.

Amendment
You have the right to request, in writing, that we amend your medical information. Your request must explain why we should amend the information. We may deny your request if we did not create the information you want amended and the person or entity that did create it is available, or we may deny your request for certain other reasons. If we deny your request, we will send you a written explanation.

You may respond with a statement of disagreement that we will add to the information you wanted to amend. If we accept your request to amend the information, we will make reasonable efforts to inform others of the amendment, including people you name, and to include the changes in any future disclosures of that information.

Electronic Notice
If you are viewing this notice on our Web site or by electronic mail (e-mail), you may request this notice in written form by using the information listed at the end of this notice.

Questions and Complaints

If you want more information about our privacy practices, or if you have questions or concerns, please contact us using the information below.

If you think that we may have violated your privacy rights, or you disagree with a decision we made about your privacy rights, you may tell us using the contact information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with that address upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Information
HCC Life
Bradley T. Long, Privacy Officer
225 TownPark Drive, Suite 350
Kennesaw, GA 30144

(800) 447-0460 (telephone)
(770) 973-9854 (fax)

EXHIBIT 16

ST ROSE HOSPITAL

27200 CALAROGA AVE

HAYWARD, CA 94545

Patient Acct#: [redacted]
Certificate: [redacted]
Claim No.: [redacted]
DOB: January 14, [redacted]
Received Date: 01/19/2016
Service Date: December 13, 2015

February 01, 2016

Dear Provider,

RE: AZAD, MOHOMMED

We are in receipt of the above-referenced claim. However, before any further consideration can be given to this claim, we will need the following information:

all medical records, provider notes, and labs from 12/09/2010 through to present date

Please return this letter with the requested information to our office within 45 days of the date of this letter, and upon receipt, we will make a determination within 30 days. Failure to respond in a complete and timely manner may result in the denial of the patient's claim(s).

CC: Member: MOHOMMED AZAD

Sincerely,
cdeputy
HCCL Claims Department
1-800-605-2282

MOHOMMED AZAD

[redacted]

[redacted]

Patient Acct#: [redacted]
Certificate: [redacted]
Claim No.: [redacted]
DOB: January 14, [redacted]
Received Date: 01/19/2016
Service Date: December 13, 2015

February 01, 2016

Dear Provider,

RE: AZAD, MOHOMMED

We are in receipt of the above-referenced claim. However, before any further consideration can be given to this claim, we will need the following information:

all medical records, provider notes, and labs from 12/09/2010 through to present date

Please return this letter with the requested information to our office within 45 days of the date of this letter, and upon receipt, we will make a determination within 30 days. Failure to respond in a complete and timely manner may result in the denial of the patient's claim(s).

CC: Member: MOHOMMED AZAD

Sincerely,
cdeputy
HCCL Claims Department
1-800-605-2282

EXHIBIT 17

MOHOMMED AZAD

[redacted]

[redacted]

Patient Acct. #: [redacted]
Certificate: [redacted]
Claim No.: [redacted]
DOB: January 14, [redacted]
Received Date: 1/29/2016
Service Date: December 27, 2015

February 11, 2016

Dear Member,

RE: AZAD, MOHOMMED

The purpose of this letter is to confirm receipt of an additional claim, referenced above. We have previously generated a letter to you requesting further information in order to determine claim benefits for the following claim(s).

Claim No.: [redacted]
Item Requested: medical records were previously requested from another provider

Date Requested: 2/1/2016

NO ACTION REQUIRED IF INFORMATION ALREADY SUBMITTED

If you have already submitted the information previously requested, please do not re-submit.

If you have yet to respond to our request, please visit https://zone.hccmis.com/clientzone/.

This claim requires receipt of the information detailed above within 45 days of the date of this request. Failure to respond in a complete and timely manner may result in the denial of your claim(s).

CC: Provider: ST ROSE HOSPITAL

Sincerely,
HCCL Claims Department
1-800-605-2282

ST ROSE HOSPITAL
KAREN LIND
27200 CALAROGA AVE

HAYWARD, CA 94545

Patient Acct. #: [redacted]
Certificate: [redacted]
Claim No.: [redacted]
DOB: January 14, [redacted]
Received Date: 1/29/2016
Service Date: December 27, 2015

February 11, 2016

Dear Member,

RE: AZAD, MOHOMMED

The purpose of this letter is to confirm receipt of an additional claim, referenced above. We have previously generated a letter to you requesting further information in order to determine claim benefits for the following claim(s).

Claim No.: [redacted]
Item Requested: medical records were previously requested from another provider

Date Requested: 2/1/2016

NO ACTION REQUIRED IF INFORMATION ALREADY SUBMITTED

If you have already submitted the information previously requested, please do not re-submit.

If you have yet to respond to our request, please visit https://zone.hccmis.com/clientzone/.

This claim requires receipt of the information detailed above within 45 days of the date of this request. Failure to respond in a complete and timely manner may result in the denial of your claim(s).

CC: Provider: ST ROSE HOSPITAL

Sincerely,
HCCL Claims Department
1-800-605-2282

EXHIBIT 18

[redacted]

Patient Acct#: [redacted]
Certificate: [redacted]
Claim No.: [redacted]
DOB: January 14, [redacted]
Received Date: 02/08/2016
Service Date: December 28, 2015

February 24, 2016

Dear Provider,

RE: AZAD, MOHOMMED

We are in receipt of the above-referenced claim. However, before any further consideration can be given to this claim, we will need the following information:

all medical records, provider notes, and labs from 12/09/2010 through to present date

Please return this letter with the requested information to our office within 45 days of the date of this letter, and upon receipt, we will make a determination within 30 days. Failure to respond in a complete and timely manner may result in the denial of the patient's claim(s).

CC: Member: MOHOMMED AZAD

Sincerely,
cdeputy
HCCL Claims Department
1-800-605-2282

MOHOMMED AZAD

[redacted]

[redacted]

Patient Acct#: [redacted]
Certificate: [redacted]
Claim No.: [redacted]
DOB: January 14, [redacted]
Received Date: 02/08/2016
Service Date: December 28, 2015

February 24, 2016

Dear Provider,

RE: AZAD, MOHOMMED

We are in receipt of the above-referenced claim. However, before any further consideration can be given to this claim, we will need the following information:

all medical records, provider notes, and labs from 12/09/2010 through to present date

Please return this letter with the requested information to our office within 45 days of the date of this letter, and upon receipt, we will make a determination within 30 days. Failure to respond in a complete and timely manner may result in the denial of the patient's claim(s).

CC: Member: MOHOMMED AZAD

Sincerely,
cdeputy
HCCL Claims Department
1-800-605-2282

EXHIBIT 19

HCC Life Insurance Company
P.O. Box 2005
Farmington Hills MI 48333-2005

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********3-DIGIT 933
27284 1 AT 0.399 99
STEVEN BUCKLEY
[redacted]

Customer Service

Date: 08/29/16
Phone: 866-400-7102
Web Address: Questions? http://service.hccmis.com
Mail to: HCC Life Insurance Company
P.O. Box 2005
Farmington Hills, MI 48333-2005

Certificate #: [redacted]
Claim #:

Provider: ACCELERATED URGENT CARE
Patient: Danielle Buckley

Dates of Service	Service Code	Total Charge	Not Covered	Reason Code	Less Discount	Less Deductible	Less Co-Pay	Amt. Subject to Coinsurance	Paid At	Patient's Share of Coinsurance	Payment Amount
06/17-06/17/2016	99204	$903.00	$903.00	86	$0.00	$0.00	$0.00	$0.00	50%	$0.00	$0.00
Column Totals		$903.00	$903.00		$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
										Other Credits or Adjustments	$0.00
										Total Net Payment	$0.00

Total Patient's Responsibility: $903.00

Service Code Description

99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of moderate complexity. Counseling and/or coordinatio

Reason Code Description

86	THIS FILE HAS BEEN CLOSED DUE TO A LACK OF REQUESTED INFORMATION FROM THE PROVIDER(S). WE NEED A COMPLETE COPY OF MEDICAL RECORDS TO REOPEN THIS FILE.

HCC Life Insurance Company
P.O. Box 2005
Farmington Hills MI 48333-2005

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

**********3-DIGIT 933
10565 1 AT 0.399 41
STEVEN BUCKLEY
[redacted]

Customer Service

Date: 08/30/16
Phone: 866-400-7102
Web Address: Questions? http://service.hccmis.com
Mail to: HCC Life Insurance Company
P.O. Box 2005
Farmington Hills, MI 48333-2005

Certificate #: [redacted]
Claim #:

Provider: ACCELERATED URGENT CARE
Patient: Danielle Buckley

Dates of Service	Service Code	Total Charge	Not Covered	Reason Code	Less Discount	Less Deductible	Less Co-Pay	Amt. Subject to Coinsurance	Paid At	Patient's Share of Coinsurance	Payment Amount
06/18-06/18/2016	99214	$1,119.00	$1,119.00	86	$0.00	$0.00	$0.00	$0.00	50%	$0.00	$0.00
Column Totals		$1,119.00	$1,119.00		$0.00	$0.00	$0.00	$0.00		$0.00	$0.00

Total Patient's Responsibility: $1,119.00

Other Credits or Adjustments $0.00
Total Net Payment $0.00

Service Code Description

99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/o

Reason Code Description

86	THIS FILE HAS BEEN CLOSED DUE TO A LACK OF REQUESTED INFORMATION FROM THE PROVIDER(S). WE NEED A COMPLETE COPY OF MEDICAL RECORDS TO REOPEN THIS FILE.

HCC Life Insurance Company
P.O. Box 2005
Farmington Hills MI 48333-2005

Explanation of Benefits

RETAIN FOR TAX PURPOSES

THIS IS NOT A BILL

Forwarding Service Requested

99

STEVEN BUCKLEY
[redacted]

Customer Service

Date: 08/29/16
Phone: 866-400-7102
Web Address: Questions? http://service.hccmis.com
Mail to: HCC Life Insurance Company
P.O. Box 2005
Farmington Hills, MI 48333-2005

Certificate #: [redacted]
Claim #:

Provider: ACCELERATED URGENT CARE
Patient: Danielle Buckley

Dates of Service	Service Code	Total Charge	Not Covered	Reason Code	Less Discount	Less Deductible	Less Co-Pay	Amt. Subject to Coinsurance	Paid At	Patient's Share of Coinsurance	Payment Amount
06/19-06/19/2016	99214	$777.00	$777.00	86	$0.00	$0.00	$0.00	$0.00	50%	$0.00	$0.00
Column Totals		$777.00	$777.00		$0.00	$0.00	$0.00	$0.00		$0.00	$0.00
										Other Credits or Adjustments	$0.00
										Total Net Payment	$0.00

Total Patient's Responsibility: $777.00

Service Code Description

99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/o

Reason Code Description

86	THIS FILE HAS BEEN CLOSED DUE TO A LACK OF REQUESTED INFORMATION FROM THE PROVIDER(S). WE NEED A COMPLETE COPY OF MEDICAL RECORDS TO REOPEN THIS FILE.